



Community Behavioral Health

PROVIDER
OPERATIONS
MANUAL

A component of the

**Department of
Behavioral Health**

serving Philadelphia's uninsured, underinsured
and Medicaid-eligible residents

Community Behavioral Health Board of Directors

Arthur C. Evans, Ph. D.
Director
Philadelphia Department of Behavioral Health

Marvin Levine
Director
Coordinating Office of Drug and
Alcohol Abuse Programs
Philadelphia Department of Behavioral Health

Michael J. Covone
Deputy Director
Philadelphia Department of Behavioral Health

Cheryl Ransom-Garner
Commissioner
Philadelphia Department of Human Services

Community Behavioral Health Executive Officers

Nancy Lucas
Chief Executive Officer

Lance R. Groff, Ph.D.
Chief Information Officer

J. Bryce McLaulin, M.D.
Chief Medical Officer

Glenn Taylor
Chief Operating Officer

Catherine Torhan
Chief Financial Officer

This Provider Operations Manual includes policy and procedure changes contained in Provider Bulletins up to 5/1/05.



CITY OF PHILADELPHIA

DEPARTMENT OF BEHAVIORAL HEALTH AND MENTAL RETARDATION SERVICES
1101 Market Street, 7th Floor
Philadelphia, Pa 19107

July 21, 2005

Dear Colleague:

We're pleased to present the newest edition of the Community Behavioral Health Provider Operations Manual. Inside you will find key policy statements and up-to-date information on obtaining authorizations and submitting claims. We've incorporated material you've received in bulletins since our last manual was published and added a number of other helpful reference tools to make your work easier.

An electronic version of the Provider Manual has been mailed to you in a CD format and is also available on the CBH website. As changes are made, we will post them on our website so that you can incorporate the updates to the Provider Manual. Printed versions are also available for providers who are unable to utilize the electronic formats.

We recognize that complying with state-mandated information requirements can be a complex task. We continue to make our staff available to you through training workshops or on-site meetings to make the process as easy as possible.

The Commonwealth's HealthChoices program and the creation of Philadelphia's Behavioral Health System in February 1997 provided all of us with the opportunity to improve and expand mental health and substance abuse services for people in need. The formal integration of all of Philadelphia's Behavioral Health System administrators (Office of Mental Health, CODAAP, and CBH) in December 2003 continued this vision. Achieving this aim continues to require a partnership between those managing public resources and those whose clinical expertise and compassion can make a real difference to the lives of Philadelphia's most vulnerable citizens. In pursuing that goal, we remain committed to playing a key role in your success, as you have played a key role in ours.

Sincerely,

A handwritten signature in black ink, appearing to read "Arthur C. Evans, Ph.D.", written over a light blue circular stamp.

Arthur C. Evans, Ph. D.

Director

Philadelphia Department of Behavioral Health



Table of Contents

INTRODUCTION

Letter From the Director of the Philadelphia Department of Behavioral Health	3
Table of Contents	4
Purpose of This Provider Manual.....	10
Frequently Called Telephone Numbers	11
Philadelphia Department of Behavioral Health.....	12
▶ Office of Mental Health and Mental Retardation	12
▶ Coordinating Office for Drug and Alcohol Abuse Programs	12
▶ Community Behavioral Health	12
Mission And Values.....	13
▶ Mission Statement.....	13
▶ Values Statement	13
Key Departments	15
▶ Provider Operations.....	15
▶ Clinical Management.....	16
▶ Member Services.....	16
▶ Network Development.....	17

COORDINATING SERVICES

Coordinating Behavioral Health with Social Services.....	2.1
Coordinating Laboratory Services.....	2.1
▶ Laboratory Authorizations.....	2.1
Coordinating Physical and Behavioral Health Services.....	2.2
▶ Coordination of Medical/Primary Care Physician and Behavioral Health Care	2.2
▶ Confidentiality.....	2.2
▶ Co-existing Physical and Behavioral Health Needs	2.3
▶ Special Needs Populations	2.3
▶ Required Reporting of Communicable Disease	2.3
▶ Behavioral Health Services at Federally Qualified Health Centers and Health Care Clinics	2.4
▶ Emergency Services.....	2.4
▶ Transportation	2.4
▶ Ambulance Companies	2.5
▶ Pharmacy	2.5
▶ Medication Problem Report	2.6

AUTHORIZATIONS

Obtaining Authorization for Services	3.1
▶ Categories of Authorization for Service.....	3.2
▶ Case Open Process	3.3
▶ DBH/CBH Referral and Authorization Process (flow chart)	3.4
How CBH Works with Clients and Providers	3.5
▶ For CBH Clients Seeking Treatment.....	3.5
▶ For Providers Seeking Authorizations	3.6
▶ Clinical Management Information Checklist	3.6
▶ Obtaining Authorizations for Service Contact Information	3.7
Beginning the Process	3.8
▶ Verifying Member Eligibility	3.8
Utilization Review Process	3.8
▶ Utilization Review	3.8
▶ Concurrent Review.....	3.9
Services That Cannot Begin Without Prior Authorization	3.10
▶ Guidelines for Prior Authorization of Inpatient Hospital Treatment	3.10
▶ Authorization Guidelines for Emergency Admissions.....	3.10
▶ Authorization Guidelines for Inpatient Psychiatric Treatment of the Uninsured	3.12
▶ Authorization Guidelines for Clients with Medicare as the Primary Carrier.....	3.13
▶ Authorization Guidelines for Medical Transfer to a Behavioral Health or Drug and Alcohol Setting/Unit.....	3.13
▶ Guidelines for Prior Authorization of Acute Partial Hospital Treatment	3.13
▶ Guidelines for Prior Authorization of BHRS and Residential Treatment Services.....	3.14
▶ Community Behavioral Health Packet Review Checklist	3.15
▶ Determining Level of Care for Adolescent Substance Abuse.....	3.18
▶ Guidelines for Prior Authorization of Psychological Testing	3.19
▶ Authorization Guidelines for Out-of-Plan and Out-of-Area Services	3.21
▶ Guidelines for Obtaining Community Support Services	3.21
Services That Can Begin Without Prior Authorization but Require an Authorization Number for Payment	3.22
▶ Guidelines for Authorization of Maintenance Psychiatric Partial Hospitalization Treatment	3.22
▶ Guidelines for Authorization of Intensive Outpatient (IOP) Drug and Alcohol Treatment	3.23
▶ Guidelines for Authorization of Psychiatric Consultations in Medical Facilities.....	3.23

▶ Guidelines for Authorization of Comprehensive Biopsychosocial Evaluations and Re-Evaluations.....	3.24
Services That Can Begin Without Prior Authorization and Do Not Require an Authorization Number for Payment	3.25
Guidelines for Extending the Authorization of Treatment Services	3.25
Discharge Standards	3.26
▶ Successful Completion of Treatment	3.26
▶ Medical Leave.....	3.26
▶ Therapeutic Leave.....	3.26
▶ Transfer to Another Level of Care	3.26
▶ Guidelines for Coverage of Children in Residential Treatment Programs Requiring Hospital Leave	3.26
▶ Against Medical or Facility Advice (AMA) or Absent Without Leave (AWOL)	3.27
▶ Guidelines for Coverage of Children in Residential Treatment Programs who are Absent Without Leave (AWOL)	3.28
▶ Guidelines for Coverage of Clients in Inpatient Drug and Alcohol Residential Rehabilitation Beds	3.29
▶ Involuntary Discharge	3.30
Resolving Disagreements about Treatment Recommendations	3.32
▶ Clinical Appeals Procedure.....	3.32
▶ Denial of Services Notification	3.33
Resolving Disagreements about Authorizations	3.35
▶ Procedure for Services that Require Prior Approval.....	3.35
▶ Procedure for Services that Do Not Require Prior Approval but Require an Authorization Number.....	3.35
▶ Procedure for Targeted Case Management and Family-Based Services	3.35
Living Arrangement, Vocational/Educational and Priority Group Codes	3.36
▶ Living Arrangement Codes.....	3.36
▶ Vocational/Educational Codes.....	3.36
▶ Priority Group Codes	3.36
Authorization Forms	3.39
▶ Case Open Request Form.....	3.39
▶ Sample DBH/CBH Authorization Letter	3.40
▶ Child/Adolescent – Behavioral Health Rehabilitative Services Packet Submission Cover Letter	3.41
▶ Child/Adolescent – Residential Treatment Facility Packet Submission Cover Letter	3.42
▶ Adolescent ASAM Summary Form (2 pages)	3.43

▶ Psychological Testing Pre-Authorization Request (2 pages).....	3.45
▶ CBH Authorization Request Form – Long-Term Partial.....	3.47
▶ CBH Intensive Outpatient (D&A) Service Request Form.....	3.48
▶ Initial Psychiatric Consultation and Follow-Up Visits in a Medical Facility.....	3.49
▶ CBH Outpatient Service Request Form.....	3.50
▶ Significant Incident Report.....	3.51
▶ CBH Authorization Correction Form.....	3.52

CLAIMS PROCESSING

Claims Submission Policies and Procedures.....	4.1
Submitting Claims to CBH.....	4.1
▶ Definitions.....	4.1
▶ Verification of Eligibility.....	4.2
▶ Coordinating Claims with Authorizations.....	4.2
▶ Non-Authorized Services.....	4.2
▶ Pricing and Information Modifiers.....	4.2
▶ Entering the Correct Year Format.....	4.2
▶ Billing for Consecutive Days – “Span Billing”.....	4.3
▶ Billing for Non-Consecutive Days.....	4.3
▶ Requirements for Provider Signature.....	4.3
▶ Third Party Liability (TPL) Billing.....	4.4
▶ TPL Medicare Inpatient Claims.....	4.4
▶ Exhausted Medicare Inpatient Lifetime Psychiatric Days.....	4.5
▶ Post-Payment Recoveries.....	4.5
▶ Member Co-Payment Prohibition.....	4.5
▶ Where to Mail Claims.....	4.5
Filing Electronic Claims.....	4.6
Filing Manual Claims.....	4.6
Claims Form Guidelines and Sample Reports.....	4.7
Specific Claims Submission Information.....	4.7
▶ Completion of the UB-92 Claim Form.....	4.7
▶ UB-92 Provider Information, Compensable Service and Patient Information.....	4.8
▶ UB-92 Third Party Liability (TPL) Billing.....	4.9
▶ Completion of the CMS 1500 Claim Form.....	4.10
▶ CMS 1500 Patient Information, Provider Name and Compensable Medical Services.....	4.11
▶ CMS 1500 for Patient TPL Billing Information, Provider Name, and Compensable Medical Services.....	4.12

Processing Payments	4.13
▶ Claims Processing Cycle.....	4.13
▶ Claims Adjustments.....	4.13
▶ Submitting Adjustments for Manual Claims	4.14
▶ Submitting Adjustments for Electronic Claims	4.14
▶ Pended Claims	4.14
▶ Rejected/Denied Claims.....	4.15
▶ Claims Appeals Process	4.15
▶ Common Causes for Claims Rejection and Remedies for Providers	4.18
Claims Reports	4.21
▶ Payment Detail Report.....	4.22
▶ Pended Claims Report.....	4.23
▶ Rejected/Denied Claims Report	4.24
▶ Rejected Claims Report - Previously Pended	4.25
Sample Claims Adjustment Request Form	4.26
Sample Forms	4.27
PROMISe Desk Chart for Assistance in the Completion of the UB-92 Claim Form	4.28
▶ UB-92 - Inpatient Claim Form	4.30
▶ UB-92 - Inpatient Third Party Liability (TPL) Claim Form.....	4.31
▶ Explanation of Benefits (EOB) for Inpatient UB-92 Third Party Liability (TPL)	4.32
Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) Desk Reference	4.33
▶ OMHSAS Desk Reference - Provider Types	4.33
▶ OMHSAS Desk Reference - Modifiers	4.34
▶ OMHSAS Desk Reference - HIPAA Place of Service Codes.....	4.35
Assistance in the Completion of the Outpatient and CMS 1500 Claim Forms	4.10
▶ CMS 1500 - Outpatient Claim Form.....	4.36
▶ CMS 1500 - Outpatient Third Party Liability (TPL) Claim Form	4.37
▶ Explanation of Benefits (EOB) for CMS 1500 Outpatient Third Party Liability (TPL).....	4.38

QUALITY MANAGEMENT

Quality Management Program	5.1
Provider's Role in the Quality Management Process	5.2
▶ Clinical Records – Access and Retention	5.2
Documentation and Reporting of Significant Incidents.....	5.3
▶ Reportable Incidents	5.3
▶ Reporting Process	5.4
▶ Where to Send Significant Incident Reports	5.4
▶ Obtaining Assistance	5.4
Confidentiality and Release of Information	5.5

NETWORK DEVELOPMENT

Network Development	6.1
The Credentialing Process	6.1
▶ Clinical Chart Audits.....	6.3
▶ Technical Assistance	6.3
▶ Program Development.....	6.4
▶ Compliance with the Americans with Disabilities Act	6.4
▶ Utilization and Supervision of Graduate Students in Field Placements.....	6.4

COMPLIANCE

DBH/CBH Compliance Policies	7.1
▶ Definitions	7.1
▶ Examples of Specifically Prohibited Activities	7.1
▶ Provider's Responsibility	7.2
▶ Monitoring of Fraud and Abuse by DBH/CBH.....	7.3

GLOSSARY

Glossary of Terms	8.1
-------------------------	-----



Purpose Of This Provider Manual

This manual describes the procedures developed by Community Behavioral Health (CBH) under the HealthChoices initiative to assure that all clients of mental health and substance abuse services receive the most appropriate treatment in the least restrictive environment possible. CBH is not only committed to helping people live in the community, but also to help people live with the community. To that end, treatment should be focused around the principles of recovery, resilience and self-determination.

The DBH/CBH Provider Manual Series consists of five separate volumes:

Volume One - Provider Operations Manual

Volume Two - Delegated Credentialing

Volume Three - Clinical Care Guide

Volume Four - Utilization Management Guide

Volume Five - Discharge Planning Guide

The Provider Manual assists network providers in meeting the requirements established for:

- ▶ authorization to provide treatment
- ▶ claims processing
- ▶ quality management
- ▶ credentialing and re-credentialing
- ▶ the complaints, grievance and appeals process
- ▶ utilization review
- ▶ determining appropriate levels of care
- ▶ the discharge planning process

DBH/CBH expects to work in partnership with stakeholders of the provider network in assuring that resources are used effectively to meet the mental health and substance abuse needs of Philadelphia's citizens. From time to time and for a variety of purposes, DBH/CBH will invite representatives from the provider network, clients and advocacy groups to sit on committees or advisory boards, to provide feedback on new ideas, or otherwise assist DBH/CBH in meeting the needs of the Philadelphia community. Instituting managed care concepts in the public sector behavioral health-care environment is a continuing challenge and requires cooperation and collaboration at all levels of the system. This manual provides a foundation for these relationships.

Frequently Called Telephone Numbers

Emergency Services	(215) 413-7171
Non-Emergency Services Requiring Prior Authorization	(215) 413-3100
Member Services	1-(888) 545-2600
Provider Relations Hotline	(215) 413-7660
Claims Hotline	(215) 413-7125

Philadelphia's Behavioral Health System

The Philadelphia Department of Behavioral Health consists of three components:

Philadelphia Office of Mental Health and Mental Retardation (OMH/MR)(215) 685-5400
 1101 Market Street, 7th Floor
 Philadelphia, PA 19107

Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP)(215) 685-5444
 1101 Market Street, 8th Floor
 Philadelphia, PA 19107

Community Behavioral Health (CBH).....(215) 413-3100
 801 Market Street, 7th Floor
 Philadelphia, PA 19107

Philadelphia Department of Behavioral Health

The County of Philadelphia has integrated its behavioral healthcare services into one comprehensive system, which became a distinct city department for behavioral health. It is comprised of the Office of Mental Health and Mental Retardation (OMH/MR), the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP) and Community Behavioral Health (CBH). This vision of an integrated behavioral health care system permits the separate funding streams of Medical Assistance, County and Commonwealth of Pennsylvania dollars to be administered by the Department of Behavioral Health (DBH). This ensures one point of accountability, as well as flexibility and cost efficiencies in the design and delivery of services.

Office of Mental Health and Mental Retardation

The Philadelphia OMH/MR is a component of DBH operated by the City of Philadelphia. Within the Commonwealth of Pennsylvania's mental health system, each county has the responsibility to serve as the central authority in providing administrative, fiscal and program planning management for a comprehensive array of services targeting persons with mental illness. OMH/MR is primarily funded by the Pennsylvania Department of Public Welfare (DPW), through State Base Allocation and Federal Block Grant dollars. Funding is also provided by the City of Philadelphia through its General Fund in order to comply with state match requirements and to further efforts to address the mental health needs of the citizens of Philadelphia.

Coordinating Office for Drug and Alcohol Abuse Programs

The CODAAP is a component of the Philadelphia DBH. It is also a Single County Authority (SCA) in the Commonwealth of Pennsylvania's drug and alcohol system. In both roles, CODAAP has responsibility for planning, funding and monitoring substance abuse prevention, intervention and treatment services within Philadelphia. CODAAP receives the majority of its funds in the form of Pennsylvania Base Allocation dollars and Federal Block Grant dollars from the Pennsylvania Department of Health (DOH). CODAAP also receives Philadelphia General Fund dollars which it uses to meet the required State match, as well as to fund services which meet the unique needs of drug and alcohol abusers living in Philadelphia.

Community Behavioral Health

CBH is the managed care component of the integrated DBH. It is one of the few behavioral health Medicaid managed care organizations in the country that is managed by a city government. Under the Pennsylvania DPW's HealthChoices initiative, CBH contracts with agencies or independent practitioners to provide in-plan mental health and substance abuse services to covered adults, children and adolescents.

CBH was created by the City of Philadelphia and is organized and operated as a nonprofit, 501c(3) corporation.

CBH is committed to providing the most appropriate and effective services possible while managing resources to best meet the needs of the Philadelphia community. The joining of managed

care concepts with public sector services creates a uniquely effective model for the management and delivery of behavioral healthcare services to Philadelphia recipients of Medical Assistance. In order to carry out these goals, CBH will:

- ▶ review the credentialing standards and procedures of agency and individual providers
- ▶ contract with those entities meeting the credentialing requirements
- ▶ authorize in-plan services under HealthChoices to be delivered to clients
- ▶ manage the utilization of those services
- ▶ pay appropriate claims for services
- ▶ maintain a quality management program and
- ▶ resolve disputes among clients, providers and CBH

The provider network is maintained at a level to accommodate these needs and allow significant choice among clients.

Mission And Values

Mission Statement

The purpose of CBH, as part of DBH, is to ensure that Philadelphia residents with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. CBH is not only committed to helping people live in the community, but also to help people live with the community. To that end, treatment should be focused around the principles of recovery, resilience and self-determination.

CBH:

- ▶ plans for and coordinates the delivery of covered services to recipients of MA and works closely with OMH/MR and CODAAP to ensure a full and appropriate range of behavioral health treatment modalities and supportive services;
- ▶ engages third parties to provide mental health and substance abuse services; and
- ▶ monitors and evaluates services and requires its contracted providers to be accountable.

Values Statement

Philadelphia is committed to a “seamless” system of care for all public sector clients. The DBH is organized around core principle of delivering high quality treatment services in a way that is fully accessible and cost efficient. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on cost efficient service. DBH utilizes the non-profit, public-sector service delivery system as the core of its treatment network.

To fulfill these values, DBH adheres to and believes in the following guiding principles:

- 1 Family integrity is of paramount importance. Needs for security, permanency and cultural ties in family relationships should pervade all planning. Families should participate fully in all decisions concerning planning, placement, program and discharge of their children and adolescents. DBH will work with all social service departments within the City of Philadelphia to achieve this outcome.
- 2 Clients should participate fully in all service planning decisions. The uniqueness and dignity of the client should govern service decisions. Individualized service plans should reflect the client's developmental needs which include family, emotional, intellectual, physical, social and cultural factors.
- 3 Culturally competent services will be guided by the concept of equal, responsive and nondiscriminatory services matched to the client population. Cultural competence involves working with natural, informal support and helping networks within minority communities. Inherent in cross-cultural interactions are dynamics which must be acknowledged, accepted and adopted. Cultural competence extends the concept of self-determination to the community.
- 4 DBH must recognize that minority populations are at least bicultural and that this status creates a unique set of mental health and substance abuse issues to which the system must be equipped to respond. Thus the system must sanction and, in some cases, mandate the incorporation of cultural knowledge into practice and policy-making.
- 5 Clients who have mental illnesses and/or substance abuse problems should be treated with dignity and respect, as they have the same needs, rights and responsibilities as other citizens. Thus these individuals should have the same access to opportunities, supports and services to help them live successfully in the community.
- 6 Services should help clients to empower themselves, focus on strengths, maintain a sense of identity and enhance self-esteem. Services should help people develop their potential for growth and movement towards independence.
- 7 Services should meet the special needs of people with mental illness and/or substance abuse problems who are also affected by one or more of such factors as: old age, physical disability, mental retardation, homelessness, the AIDS virus and/or involvement in the criminal justice system.
- 8 Services should be coordinated through mandated linkages with clients/families, both at the local and state levels. Continuity of care for people discharged from hospitals to community-based services must also be ensured.
- 9 Treatment providers should be accountable to clients, who should help plan, implement, monitor and evaluate the services they receive.

Key Departments

The following is intended to introduce key departments within CBH and provide basic information about them. Detailed information about each department will be provided in later sections of this manual as necessary. Following are brief summaries of the departments working most closely with the provider network: Provider Operations, Clinical Management, Member Services and Network Development.

Provider Operations



Provider Hotline: (215) 413-7660
Monday-Friday, 8:30 am–5:00 pm

Provider Operations, which consists of Provider Operations, Quality Review, and Contracting is designed to contract, maintain and coordinate a comprehensive network of treatment providers. As a liaison between DBH/CBH and providers, this department is responsible for providing the support and resources necessary for maintaining the provider network. In addition, Provider Operations is also responsible for supporting quality management of providers including the resolution of client complaints and grievances.

Quality Review monitors and evaluates behavioral health services in order to ensure that the best treatment options are provided to clients in a culturally sensitive and quality-driven environment. To this end, Quality Review monitors complaints, incidents and quality concerns, and audits activities to determine compliance with established quality of care standards. Quality Review also establishes objective and measurable criteria to assess client care, and establishes a system, which identifies risk potential to clients or providers.

Provider Relations/Contracting:

- ▶ helps triage all non-clinical issues from providers
- ▶ offers assistance to providers in various capacities
- ▶ clarifies policies and procedures
- ▶ interprets contract language and rates
- ▶ works jointly with the Claims Department to resolve payment issues
- ▶ moves provider complaints and grievances through the system
- ▶ assists providers in accessing the information or department they need

Clinical Management



Clinical Management—Emergency: (215) 413-7171

24 hours a day, 7 days a week

Clinical Management—Non-Emergency: (215) 413-3100

Monday-Friday, 8:30 am–5:00 pm

Clinical Management assures that each client receives a comprehensive array of clinical services at the appropriate level of care in the least restrictive environment. Clinical Management, along with Medical Affairs, coordinates the ongoing treatment of each client.

Clinical Management is responsible for:

- ▶ coordinating care
- ▶ determining levels of care
- ▶ authorizing services
- ▶ conducting concurrent reviews
- ▶ conducting retrospective reviews
- ▶ maintaining a clinical liaison with providers
- ▶ resolving problems related to utilization management issues.

Member Services



Member Services: 1-(888) 545-2600

24 hours a day, 7 days a week

Member Services is dedicated to ensuring that all clients obtain needed services and works to remove barriers to treatment. Member Services works closely with all other DBH departments to assure that DBH/CBH clients obtain prescribed services. Member Services staff include individuals who have first-hand experience as clients or family members of those in recovery from behavioral health issues.

Member Services is responsible for:

- ▶ working directly with clients
- ▶ functioning as internal ombudspersons
- ▶ recording initial information about client complaints or grievances and resolving service-related issues, and forwarding it to Provider Operations for a quality review and investigation.

- ▶ confirming client eligibility
- ▶ collecting relevant demographic clinical information about the client
- ▶ scheduling appointments for assessments
- ▶ determining special needs

Network Development



Network Development: (215) 413-3100
Monday-Friday, 8:30 am–5:00 pm

Network Development is responsible for credentialing and re-credentialing providers in the DBH/CBH network. DBH/CBH staff review the qualifications of professional and paraprofessional staff employed by treatment providers in the network, and examine provider policies and procedures that are an integral part of the assurance of the delivery of quality care.

The department also performs on-site clinical audits, either as a part of a credentialing visit or as a result of concerns about quality of care issues raised about a provider. Further, the department includes Clinical Systems Analysts who provide technical assistance, education and consultation services to providers in the network. When Network Development and Provider Operations identify systemic problems during the audit, review and quality management process, Clinical Systems Analysts are contacted to serve as short-term consultants. They assist agency staff in rectifying problems and address issues relevant to the provision of quality care.

Network Development is also charged with program development with new or existing providers.



Coordinating Behavioral Health with Social Services

As a key component of the Department of Behavioral Health (DBH) managed by the City of Philadelphia, Community Behavioral Health (CBH) is uniquely equipped to facilitate cooperation between behavioral health and other key social services. DBH exists within the city structure as part of the overarching Department of Social Services. As a result, the DBH is connected to the Departments of Human Services, Aging, Adult Services, Recreation and the Prison System. These ongoing structural relationships allow for unified planning, sharing of common resources and the development of a social service delivery system so that a Philadelphia citizen only needs to walk through one door to obtain service. In addition, an agreement is held between the DBH and the Philadelphia School District to coordinate the provision of behavioral health services to children in schools. Providers are also responsible for coordinating care for clients with the appropriate social service agencies as necessary and as directed by CBH, OMH/MR and CODAAP.

Coordinating Laboratory Services

CBH is financially responsible for all laboratory work ordered by its behavioral health providers. Providers should refer all routine lab work to a CBH contracted laboratory, while emergency lab work should be referred to a participating hospital. The participating laboratories will bill CBH for all lab work ordered by its providers.

DBH/CBH currently has contracts with the following commercial laboratories:

	Bendiner and Schlesinger.	(212) 254-2300
	DeJohn Medical Laboratories, Inc.	(610) 626-2112
	International Medical System Laboratories . . .	(610) 292-0613
	Parkway Clinical Laboratories	(215) 245-5112
	Princeton Biomedical Laboratories.	(215) 785-5200
	TechNow, Inc..	(610) 362-0610

In addition to these commercial labs, CBH participating hospitals may also use their on-site laboratories.

Laboratory Authorizations

Commercial and hospital laboratories are not required to call CBH for authorizations but should submit a claims form for payment. When completing the claims form, laboratories should use "0" in the authorization number field. However, labs must insure that the individuals for whom they conduct tests are CBH clients at the time the service is performed and that all tests performed are listed as reimbursable services in the CBH Laboratory Fee Schedule. Claims will reject if the client is not eligible on the date of service and/or if the test performed is not a CBH reimbursable service.

Coordinating Physical and Behavioral Health Services

In Philadelphia County, there are currently three physical health Managed Care Organizations (MCOs) participating in HealthChoices: Health Partners Plan of Philadelphia, Inc., AmeriChoice of Pennsylvania, and Keystone Mercy Health Plan. Coordination with these HMOs allows for the creation of a seamless system of physical and behavioral healthcare for clients and the cost-effective use of resources. It is essential that there be collaboration, cooperation, interaction, identification and resolution of problems between and among the HMOs, DBH/CBH and the provider network. This section outlines the primary areas of coordination.

Coordination of Medical/Primary Care Physician and Behavioral Health Care

Behavioral health treatment providers are expected to coordinate care with the Primary Care Physician (PCP). This includes but is not limited to the following:

- ▶ identifying the client's PCP and obtaining appropriate releases to share relevant clinical information
- ▶ assessing the patient's needs for care, coordinating with the client's PCP and making appropriate referrals
- ▶ providing health records to each other as requested
- ▶ notifying each other of all prescriptions and, where deemed advisable, checking with each other before prescribing medication
- ▶ making certain both behavioral health providers and PCPs have a complete, up-to-date record of medications
- ▶ being available for consultation
- ▶ participating in Interagency Team meetings when necessary

Confidentiality

Both physical and behavioral health providers are responsible for obtaining all releases, adhering to consensual and non-consensual guidelines and informing DBH/CBH of the status of the client's consent. DBH/CBH will monitor these responsibilities through chart audits.

Co-existing Physical and Behavioral Health Needs



**Only DBH/CBH can authorize and reimburse providers for behavioral services.
Only a HMO can authorize and reimburse providers for medical services.**

Outpatient providers must report all medical needs to the PCP for follow-up. Inpatient providers must notify the PCP of admissions and any changes in the client's status. Routine inpatient medical services such as physical exams, pharmacy, radiology and lab services are included in the facility's per diem.

For emergency medical services, the provider should notify the client's HMO Utilization Management Department within 24 hours. If a medical consult is needed, prior authorization is not required for the initial consultation, but the HMO Utilization Management Department should be notified as soon as possible. Medical conditions not requiring immediate attention should be reported to the PCP.

Special Needs Populations

Special needs populations are a high priority for both DBH/CBH and the HMOs. Providers may be asked to participate in Interagency Team meetings and in the development of specialized plans for clients with multiple needs such as:

- ▶ persons with HIV
- ▶ drug-addicted pregnant women
- ▶ persons with mental retardation
- ▶ persons with physical disabilities
- ▶ persons with co-occurring disorders

Any concerns regarding the coordination of physical and behavioral health services should be referred to the CBH Chief Medical Officer.

>>> REQUIRED REPORTING OF COMMUNICABLE DISEASE <<<

In accordance with Pennsylvania Disease Prevention and Control Law of 1955 (35 PS sections 521.1 - 521.21), all providers, including physicians, licensed health practitioners and any other persons having knowledge or suspicion of a reportable disease or condition, shall report it promptly to the Disease Control Unit within the Philadelphia Department of Public Health at (215) 685-6740.

Providers having any questions regarding compliance with this law should call the Disease Control Unit directly.

Behavioral Health Services at Federally Qualified Health Centers and Health Care Clinics

The Philadelphia Department of Public Health operates eight Federally Qualified Health Centers throughout the City. These centers meet standards set by the Pennsylvania Department of Health, Bureau of Community Health and some of these centers also provide behavioral health services. DBH/CBH is committed to ensuring reasonable access to licensed behavioral health services provided by Federally Qualified Health Centers and clinics within 30 minutes for residents of urban areas. CBH Care Managers also work with clinic and center staff on client-specific issues. In addition:

- ▶ Whenever possible, DBH locates assessment services in Federally Qualified Health Centers and health care clinics.
- ▶ Health clinics and centers which provide behavioral health services to clients are required to follow procedures outlined in this Provider Manual.

Emergency Services

CBH is clinically and financially responsible for Emergency Room evaluations for voluntary drug/alcohol/mental health admissions, or involuntary mental health commitments pursuant to the 1976 Mental Health Procedures Act. However, if the patient is admitted, the per diem will include the payment for the evaluation. All other emergency services are the clinical and financial responsibility of the HMO. Disputes regarding the responsibility for emergency services must not delay services to the client.

Transportation



CBH does not pay for transportation.

The HMO is responsible for all emergency medical and/or non-emergency medically necessary ambulance transportation for clients receiving both physical and behavioral healthcare.

The provider is responsible for making transportation arrangements using the HMO's contracted transportation services.

AMBULANCE COMPANIES

The HMOs contract with the following ambulance companies:

	Physician Choice Ambulance	(215) 482-8560
	NuCare	(215) 877-5900
	Network Ambulance Co.	(215) 476-3800
	Keystone Quality Transport	(215) 492-5880

Non-emergency transportation is the financial responsibility of the treatment provider that receives the client. If the receiving provider fails to pay the non-emergency fees for which it is responsible, DBH/CBH reserves the right to pay the service and then deduct the applicable amount from future claims submitted by that provider.

Wheels of Wellness, Inc., (215) 563-2000, provides routine pre-arranged transportation for outpatient services within Philadelphia County.

Pharmacy

All outpatient prescriptions must be filled at the client’s HMO participating pharmacies. When DBH/CBH clients are denied or have difficulty acquiring prescribed medications by pharmacies contracted with their HMOs, prescribing physicians are requested to complete a **Medication Problem Report** form. (See next page.) This form should be faxed to Medical Director, OMH/MR, at (215) 685-5467.

PHILADELPHIA BEHAVIORAL HEALTH SYSTEM

Office of Mental Health
 Coordinating Office for Drug and Alcohol Abuse Programs
 Community Behavioral Health

MEDICATION PROBLEM REPORT**(TO BE FILLED OUT BY PRESCRIBING PHYSICIAN)**

Please check all that apply, fill in the blanks as necessary, and please print

Client unable to obtain medication because of HMO/pharmacy denial

Keystone Mercy Health Plan

Health Partners

Americhoice of PA

Pharmacy name _____ Pharmacy phone _____

Pharmacy address _____

Name of medication _____

Questions to Physician

Were you aware of the need for preauthorization, if indicated? Yes No

Did the pharmacist call you? Yes No

Was the 72-hour supply provided to the client? Yes No

Did you speak to the HMO? Yes No

Time of day _____ HMO staff name _____

Were you able to obtain the prior authorization within 24 hours? Yes No

If no, why? _____

Name of physician _____

Agency _____

Phone _____ Fax _____

Signature _____ Date _____

PLEASE FAX THIS FORM TO: Medical Director, OMH/MR Fax: (215) 685-5467 Telephone: (215) 685-5460



Obtaining Authorization for Services

This chapter describes the procedures that treatment providers must follow to obtain authorizations for treatment of Department of Behavioral Health/Community Behavioral Health (DBH/CBH) clients. The process of coordinating client care is at the core of the managed care concept. Authorizing services enables the managed care organization to have knowledge of the needs of its clients, the capacities of its provider network, and the extent of its fiscal responsibilities.

The authorization process involves the following steps:

- ▶ verifying that the individual is eligible for the services requested
- ▶ assessing the needs of clients, consistent with medical necessity criteria
- ▶ obtaining the initial authorization to begin treatment
- ▶ assessing progress or utilization of the services as they are provided

DBH/CBH clients with behavioral health needs must have ready access to the most appropriate treatment service and level of care. DBH/CBH utilizes the Commonwealth of Pennsylvania's Medical Necessity Criteria in issuing service authorizations. **(A copy of HealthChoices Behavioral Health RFP, Appendix T is available from upon request by calling CBH Provider Relations at (215) 413-7660.)** The length of an authorization is never based solely on diagnosis or type of illness/condition. We strive to ensure that:

- ▶ care is provided in the most appropriate and least restrictive setting
- ▶ authorizations are standardized, coordinated and expedited
- ▶ length of stays that are not medically warranted are prevented
- ▶ costs are controlled

Categories of Authorization for Service:

1 THE FOLLOWING CLINICAL SERVICES CANNOT BEGIN WITHOUT PRIOR AUTHORIZATION:

- ▶ all inpatient behavioral health services
- ▶ all detoxification, residential rehabilitation, and half-way house services
- ▶ all psychiatric acute partial hospitalization services for adults and children
- ▶ all Behavioral Health Rehabilitation Services (BHRS)
- ▶ all residential treatment services for children and adolescents
- ▶ all psychological testing
- ▶ all out-of-plan or out-of-area services
- ▶ community support services
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the authorization process outlined under **Services than Cannot Begin Without Prior Authorization**.
- ▷ Community Support Services (TCM, Crisis Residences and Family-Based are authorized through OMH/MR).

2 THE FOLLOWING CLINICAL SERVICES CAN BEGIN WITHOUT PRIOR AUTHORIZATION BUT REQUIRE AN AUTHORIZATION NUMBER FOR PAYMENT:

- ▶ all maintenance partial hospitalization services
- ▶ all Intensive Outpatient Provider (IOP) services
- ▶ all initial and follow-up psychiatric consultations
- ▶ all Comprehensive Biopsychosocial Evaluations (CBEs) and Re-evaluations (CBRs)
- ▶ all emergency psychiatric evaluations
- ▶ all court evaluations
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the authorization process outlined under **Services That Begin Without Prior Authorization and Do Not Require an Authorization Number for Payment**.

3 THE FOLLOWING CLINICAL SERVICES CAN BEGIN WITHOUT PRIOR AUTHORIZATION AND DO NOT REQUIRE AN AUTHORIZATION NUMBER FOR PAYMENT:

- ▶ all outpatient mental health and drug and alcohol services
- ▶ all methadone maintenance clinic services
- ▶ all assessments
- ▶ Crisis Response Center (CRC) evaluations
- ▷ This clinical category includes initial and concurrent treatment episodes.
- ▷ Providers must follow the instructions outlined under **Services That Can Begin Without Prior Authorization and Do Not Require an Authorization Number For Payment**.

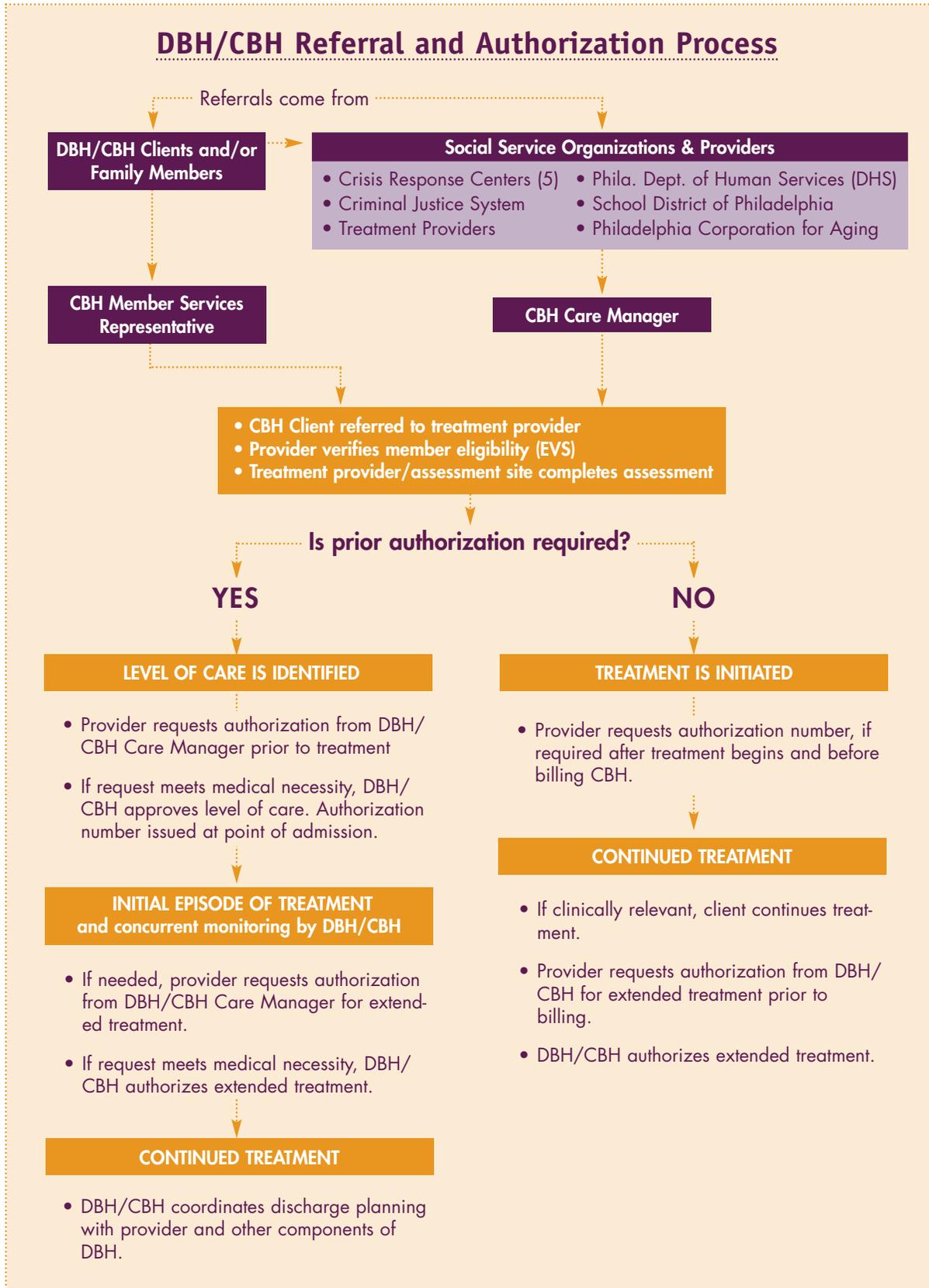
Case Open Process

Providers must request cases to be opened for CBH clients who fall in one of the categories listed below:

- ▶ Clients who are newly enrolled in Medical Assistance. This includes clients who have transferred from another county to Philadelphia and those previously funded for drug and alcohol outpatient services under the Behavioral Health Special Initiative (BHSI) and have converted to CBH.
- ▶ Clients who have never received inpatient or outpatient behavioral health services under CBH.

Providers should complete a CBH **Case Open Request Form** for clients who meet the above criteria. The forms must be submitted on a weekly basis to the Data Entry Supervisor, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Cases will be opened within two weeks from the date CBH receives the request and providers will have 90 days from the date of service to bill for services. Failure to open a case will not be cause to extend billing time frames.

This chart illustrates the ways DBH/CBH clients are referred for treatment and the steps treatment providers must take to obtain authorization.



How CBH Works with Clients and Providers

CBH assists both clients and providers as they proceed through the authorization process.

For CBH Clients Seeking Treatment

MEMBER SERVICES UNIT

The CBH Member Services Unit is available for **clients** to call when they want to schedule an initial appointment for services. The Member Services Unit is also available to assist providers in referring a client to treatment services that may more closely meet the client's needs.

This unit is responsible for:

- ▶ confirming client's eligibility
- ▶ collecting relevant demographic information about the client and reason for referral
- ▶ scheduling appointments for assessments
- ▶ determining special needs
- ▶ making referrals to treatment providers
- ▶ ensuring clients have a choice of treatment program

Member Services Representatives will always attempt to conduct a three-way call with the client and provider when scheduling an appointment at a provider site. In instances where CBH reaches the provider's voicemail, the Member Services Representative will leave a message requesting an appointment. The provider is responsible for returning the call to the Member Services Representative and providing an appointment date, time and place. CBH will then inform the client.

When clients contact the Member Services Unit during non-business hours and weekends, the Member Services Representative will call the identified provider the next working day to obtain an appointment then notify the client of the date, time, and location of the appointment.

Providers are required to cooperate with CBH in scheduling assessments.



Member Services Unit:

1-(888) 545-2600

24 hours a day, 7 days a week.

For more information about services available to members and member rights, please see the **CBH Member Handbook** (Appendix A).

For Providers Seeking Authorizations

CLINICAL MANAGEMENT

Clinical Management is available for providers to call to request treatment service authorizations, or if needed, to obtain information on other providers to whom they may refer a client. In addition, Clinical Management is responsible for:

- ▶ coordinating care
- ▶ determining level of care
- ▶ authorizing services
- ▶ conducting concurrent reviews
- ▶ maintaining a clinical liaison with providers
- ▶ resolving problems related to utilization management

When calling Clinical Management, please have as much Medical Assistance, demographic, and clinical information available as possible.

Clinical Management Information Checklist

- ▶ provider's name and facility
- ▶ demographics of client (age, marital status, race, gender)
- ▶ Axis 1-5 must include DSM IV code for Axis -1
- ▶ ICM or RC (indicate whether or not client has name, agency, or phone number of ICM or RC)
- ▶ presenting problem (includes special needs)
- ▶ Mental Status Examination (MSE) must include physician's name (in D&A cases, if MSE is not presented, indicate whether or not mental health issues exist)
- ▶ medications, dose and frequency (indicate last date of compliance or noncompliance)
- ▶ D&A history (name of drug, amount used, route of administration, duration of use, and date of last use)
- ▶ oral fluid/drug screen/blood alcohol results
- ▶ supports
- ▶ treatment plan
- ▶ living status
- ▶ legal



OBTAINING AUTHORIZATIONS FOR SERVICE

For Emergency Inpatient Mental Health and Drug & Alcohol Services

call Clinical Management 24 hours a day, 7 days a week
(215) 413-7171

For All Non-Emergent Services Requiring Prior Authorization,

call Clinical Management Monday-Friday, 8:30 am-5:00pm
(215) 413-3100

For All Non-Emergent Services Requiring an Authorization Number

Complete an **Outpatient Service Request Form** and mail it to:

Data Entry Department
CBH
801 Market Street, 7th Floor
Philadelphia, PA 19107

Beginning the Process

Verifying Member Eligibility

Prior to treatment, providers are responsible for verifying that individuals are eligible for Medical Assistance and enrolled in a Health Maintenance Organization (HMO).

The Commonwealth of Pennsylvania Department of Public Welfare issues a Medical Assistance (MA) Access card to all Medical Assistance recipients at the time they are initially enrolled in the MA program. The Pennsylvania Department of Public Welfare (DPW) maintains a list of the current status of all MA recipients and updates this list daily. Providers are required to check the member's eligibility every time service is provided.

In order to receive payment for services rendered, providers must check the member's eligibility. Providers can access the DPW's daily eligibility file by phone by calling (800) 766-5387.

Providers may also use the various methods described on DPW's website:

www.dpw.state.pa.us/omap/provinf/omapevs.asp

Utilization Review Process

Utilization Review

Utilization review is the process by which Care Management staff determine the initial level of care. This process ensures that the quality of treatment is consistent with recognized and accepted medical standards and appropriate to the client's presenting symptoms as well as physical, psychological, and social needs.

The initial review process will attempt to:

- 1 Identify drug and alcohol issues, particularly withdrawal symptoms, specific drugs used, patterns of use, consequence of use, risk factors, and medical complications related to use.
- 2 Identify psychiatric symptomatology present through observation and from information collected by the individual and/or family. This includes a Mental Status Exam (MSE) that determines the individual's thought content, judgment and insight, motor activity, sensorium, mood/affect, suicidal/homicidal ideation/plans, etc., and documents:
 - ▶ recent hospitalizations
 - ▶ current medications
 - ▶ primary physician/psychiatrist and/or treatment program in which currently enrolled
 - ▶ ICM/RC/BHSI case management
 - ▶ DHS involvement
 - ▶ trends/patterns of decompensation
 - ▶ legal involvement
 - ▶ barriers to treatment

- 3 Identify medical issues that may pose an immediate risk to the individual, and in cases of pregnant women, that may place the fetus at significant risk due to the lack of prenatal care, given the factors identified in 1 and 2 above.
- 4 Identify special needs such as medical conditions, cognitive disabilities, women with children, cultural issues/barriers, hearing and sight impairments, developmental disabilities, etc.
- 5 Identify environmental conditions that place an individual at risk of harm, reduce the opportunity for abstinence, etc. This will include issues such as recent eviction, lack of permanent housing, multiple foster placements, living with others who may be using substances, or any other factors that may inhibit or support continued symptoms.

All requests for authorization will be based on the Medical Necessity Criteria (Appendix T) of the HealthChoices Behavioral Health Program Standards (available upon request from CBH's Provider Operations at **(215) 413-7660** or on the Pennsylvania Client Placement Criteria.

Concurrent Review

Concurrent review is the process by which DBH/CBH assesses the care being given a client to insure that the treatment is clinically appropriate, effective, and adequate.

DBH/CBH may require that the agency/facility send copies of the records on which clinical recommendations are based when there is a question related to the validity of the clinical information given over the phone. The Release of Information form has already been signed by the consumer at the start of treatment to facilitate information sharing. (Please note that the provider is responsible for the cost of these copies and postage.)

The concurrent review process may result in a determination that a client needs different, additional, or lesser care than that being recommended by the current provider. This decision may be appealed according to the Authorization Appeals Procedure detailed later in this section.

Services provided to DBH/CBH clients that require prior authorization are subject to concurrent review. If the level of care changes during a service period or is specified as specialized care, a separate authorization will be issued for the new level of care. In addition, if the person needs to be transferred to a different facility or location, the facility must obtain an authorization from DBH/CBH to do so. DBH/CBH can provide information to the client and the provider about other agencies within the CBH network who provide the type of services needed. It is the current provider's responsibility to make the referral and the transportation arrangements as necessary. Please refer to **Coordination of Transportation** in the Coordinating Services section of this manual for further details.

Events which are identified to have quality of care concerns or risk issues are referred to the Manager of Quality Review and the Director of Clinical Management, who will investigate and forward the findings to the Director of Medical Affairs for review, recommendations or follow-up action.

Please see the **Care Management Unit Reference Guide** for a summary view of authorization and concurrent review information.

Services That Cannot Begin Without Prior Authorization

There are specific services that the treatment provider cannot begin providing without obtaining prior authorization. These include:

- ▶ all inpatient behavioral health services
- ▶ all detoxification, residential rehabilitation, and half-way house services
- ▶ all psychiatric acute partial hospitalization services for adults and children
- ▶ all Behavioral Health Rehabilitation Services (BHRS)
- ▶ all residential treatment services for children and adolescents
- ▶ all psychological testing
- ▶ all out-of-plan or out-of-area services
- ▶ community support services

Guidelines for Prior Authorization of Inpatient Hospital Treatment

When a DBH/CBH Care Manager reviews the Medical Necessity Criteria regarding an individual member and agrees that inpatient hospital treatment is medically necessary, they will authorize treatment under one of the following levels of care:

INPATIENT PSYCHIATRIC HOSPITAL TREATMENT

- ▶ inpatient acute
- ▶ inpatient sub-acute
- ▶ acute 302
- ▶ 23-hour bed

INPATIENT AND NON-HOSPITAL BASED DRUG AND ALCOHOL TREATMENT

- ▶ hospital and non-hospital based detoxification
- ▶ hospital and non-hospital based residential rehabilitation
- ▶ half-way house services

Authorization Guidelines for Emergency Admissions

The following are the authorization guidelines providers should follow when calling CBH on behalf of a client who is experiencing a psychiatric or drug and alcohol emergency. An emergency is defined as **Emergent** or **Urgent** and is not limited to a prescribed set of diagnoses or symptoms. An individual with an emergent condition presents with acute, severe symptoms (including severe pain) that requires immediate medical attention and that, to ignore, would result in:

- ▶ serious jeopardy to the life of the individual (or, in the case of a pregnant woman, the woman or her unborn child)
- ▶ serious impairment to bodily functions
- ▶ serious dysfunction of any bodily organ or part

Emergent care differs from urgent care in that urgent conditions, if left untreated (particularly within a 24-hour period) could become emergent. **All other situations which do not fall under emergent or urgent are considered routine.**

EMERGENT AND URGENT AUTHORIZATION PROCEDURE:

In order to be admitted to an inpatient unit, a client must be evaluated by a psychiatrist at a hospital emergency room or Crisis Response Centers (CRC) in the city of Philadelphia. This examination must include a Mental Status Evaluation (MSE). In order to be admitted to a medically managed or medically detoxification, residential rehabilitation facility or halfway house, a client should be assessed according to Pennsylvania Client Placement Criteria (PCPC).

- 1 The provider calls CBH Clinical Management at **(215) 413-7171**. Please note that the provider is not calling a specific person when calling this number, but is asking to speak with someone to present an individual for psychiatric or drug and alcohol admission.
- 2 The Care Manager will request the client's MA recipient number, the client's eligibility for Medical Assistance, and pertinent clinical information to support the mental health or drug and alcohol diagnosis, using the DSM-IV diagnostic criteria. Please refer to the **Case Management Information Checklist** for a list of points providers should be prepared to discuss with a Care Manager when calling in for an Emergent or Urgent authorization.
- 3 If the provider and the DBH/CBH Care Manager agree on the treatment recommendation, the Care Manager will ask where the client wants to be admitted. DBH/CBH emphasizes client choice. When necessary, DBH/CBH is available to assist in the placement process. The Care Manager instructs the provider to have the admitting facility call CBH to get the authorization number once the person is admitted to the floor. When the admitting provider calls, the Care Manager will generate an authorization number and inform the provider by telephone. The number will also be forwarded by letter to the provider.

NOTE: Only one authorization number per inpatient stay is issued, except when the level of care changes during a stay.

NOTE: As CRC and emergency psychiatric evaluations do not require prior authorization, payment will not be denied, provided all authorization and billing procedures are followed.

Authorization Guidelines for Inpatient Psychiatric Treatment of the Uninsured

County Funding is used for uninsured Philadelphia residents in need of acute psychiatric services and is managed by CBH and the Office of Mental Health and Mental Retardation (OMH/MR).

- ▶ The acute inpatient level of care will be determined in accordance with Medical Necessity Criteria outlined in Appendix T of HealthChoices and the Clinical Care Guide.
- ▶ CBH will authorize placement and encourage treatment providers to enroll individuals in Medicaid, if they qualify, as soon as possible.
- ▶ Uninsured clients in need of primary drug and alcohol treatment should be referred to the Behavioral Health Special Initiative (BHSI).
- ▶ Individuals from other counties and/or states will be referred to their respective Offices of Mental Health and will not be approved for County Funding.
- ▶ Once a child or adolescent is admitted into treatment under County Funding, providers are required to conduct concurrent reviews with CBH Care Managers. Failure to do so will result in withdrawal of authorization and OMH will not reimburse for services.

OBTAINING AUTHORIZATION FOR INPATIENT HOSPITALIZATION FOR THE UNINSURED

- ▶ Provider establishes Philadelphia residency and insurance status of client through the use of the EVS. If the individual meets Medical Necessity Criteria for acute inpatient psychiatric treatment, contact the CBH Crisis Line at **(215) 413-7171** and present the individual for admission.
- ▶ CBH Care Manager verifies insurance status of the client through EVS and PROMISe.
- ▶ Once the individual is under consideration for County Funding, the Care Manager will record the assessment information ascertained by the provider and, if appropriate, authorize admission under County Funding which may be for up to 5 days for involuntary commitments. The Care Manager will also record the number of days initially authorized.
- ▶ All County Funding information is documented and retained for submission to OMH.
- ▶ For children and adolescents, the respective DBH/CBH Care Manager will conduct concurrent review with the treatment provider following the initial authorization period.
- ▶ Decisions to deny initial or concurrent stays will be reviewed through the physician review process and will be documented on the original form.
- ▶ Once the approved criteria for County Funding have been met, complete the following guidelines:
 - Verify compliance to client liability determination standards for DBH programs. The provider hospital is responsible for conducting the assessment to determine the client's and/or their legal responsible relative's ability to cover the cost of care.
 - Verify that an MA application was made on behalf of the client upon hospital admission and that DPW rejected the client's application for reasons other than excessive income,

insufficient information, or other non-medical reasons. It is the hospital staff's primary obligation to follow-up with clients regarding DPW requirements.

- If a client is determined to be financially liable, the hospital must make collection arrangements with the client. Collected funds must be deducted from any request for county reimbursement. Verification of an exhaustive collection effort must include proof that the delinquent payment was submitted to a collector and credit bureau for credit reference. Please note that County Funding will not be available to reimburse inpatient stays for individuals who have used their annual or lifetime benefits from other third parties.

Authorization Guidelines for Clients With Medicare as the Primary Carrier

When a CBH client is also covered by Medicare and meets medical necessity criteria for inpatient or residential treatment services, the provider will need to:

- ▶ Verify coverage and the number of remaining covered days prior to contacting CBH.
- ▶ Obtain an authorization number prior to billing for third-party liability payment, even if there are remaining covered days and no pre-certification is necessary. It is the preference of CBH that clinical information be presented for continuity of care purposes.
- ▶ Proceed with the pre-certification process if the member has no remaining covered days.

Authorization Guidelines for Medical Transfer to a Behavioral Health or Drug and Alcohol Setting/Unit

In situations where it is necessary to move an individual from a medical facility to an inpatient psychiatric unit or drug and alcohol inpatient unit, a psychiatric evaluation must be completed by a licensed psychiatrist prior to presenting the individual for admission.

When there is a need to move an individual from a psychiatric inpatient unit to a substance abuse treatment setting, or vice versa, the Care Manager will assist the provider in identifying other agencies within the CBH network that provide needed services. The Care Manager, in conjunction with the provider, will make referrals, taking into consideration the client's preference. The referring provider will also arrange appropriate transportation.

Guidelines for Prior Authorization of Acute Partial Hospital Treatment

Acute partial hospitalization is a non-residential hospital-based program designed for the treatment of individuals with acute psychiatric illness or acute exacerbation of chronic psychiatric illness.

It provides an array of intensive psychiatric, medical, behavioral, and developmental services to address the acuity and severity of the individual's psychiatric symptoms in situations in which hospitalization is not required. The goal of the acute partial hospital program is to increase the level of patient functioning. Its objectives include:

- ▶ Crisis stabilization and treatment of persons with serious and persistent mental illness who are currently in treatment and require more intensive services than are provided in an outpatient setting

- ▶ Client's return to the community

Psychiatric acute partial hospitalization treatment services require prior authorization by Clinical Management.

Initial authorization for acute partial can be obtained:

- 1 As a "step-down" from acute and sub-acute inpatient treatment.** Admission into acute partial will be authorized by the Care Manager conducting the concurrent review for acute/sub-acute inpatient treatment. As part of the concurrent review process, the Care Manager confirms that the client is able to step-down into that level of care, has the capacity to participate in partial hospitalization services, and has a community-based network of supports. The Care Manager will authorize the initial admission as part of the discharge plan to the next level of care.
- 2 As a "step-up" from outpatient treatment.** Individuals attending outpatient treatment who require more intensive structure may be authorized for acute partial. In these cases, services must be authorized through the CBH Crisis Response Line at **(215) 413-7171**. These cases are authorized within 24 hours from the point of the assessment.
- 3 As a direct entry into acute partial from an assessment site.** When persons are assessed and found to be in need of more structure but do not need inpatient treatment, the assessment provider should contact the CBH Crisis Response Line at **(215) 413-7171** for authorization within 24 hours from the initial assessment.

The initial authorization will be up to 10 days for adults, and 5 days for children and adolescents, if Medical Necessity Criteria (see Appendix T or the Clinical Care Guide) are met. It is anticipated that the maximum length of stay in acute partial will be 20 days. If it is determined that a client requires additional time in this level of care, a physician review will be done to determine continued medical necessity. Authorizations will be granted according to the individual needs of the client and in conjunction with the physician review and recommendations for continued stay.

Guidelines for Prior Authorization of BHRS and Residential Treatment Services

Community Residential Rehabilitation (CRR) Host Homes, Residential Continuum Treatment Facilities (RCTFs), Residential Treatment Facilities (RTFs), and Behavioral Health Rehabilitation Services (BHRS) programs have a responsibility to meet the needs of children in their care as they move through a continuum of treatment services. DBH/CBH places a priority on continuity both within and between levels of care and expects treatment providers to actively work with clinical staff and families to help children make the transition between levels of care.

These services should be therapeutically appropriate, demonstrate cultural competence and meet the individual needs of children and adolescents, whether the service is delivered in the home, school, at work or in the community.

PREPARING CHILD AND ADOLESCENT PACKETS

Below are the criteria providers must follow when preparing the packet required for authorization of BHRS, RCTF, RTF, CRR, Host Homes and Partial Hospitalization services for children and adolescents. To streamline the process of reviewing authorization requests, providers must also complete and include a copy of the **Child/Adolescent Packet Submission Cover Letter** with every packet.

COMMUNITY BEHAVIORAL HEALTH PACKET REVIEW CHECKLIST

MA-97 OR MA-325

- Requests services accurately, including an appropriate start date.
- Signed by client/guardian and prescriber. (Prescriber is the licensed psychologist or psychiatrist who completed the evaluation.)

COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION (CBE)

- Describes background data, family information, and developmental history.
- Reviews history of presenting problem, services utilized, and progress made.
- Identifies strengths.
- Considers continuum of alternative services and describes need for BHRS, RCTF, RTF, CRR, Host Homes or Partial Hospitalization services.
- Contains Mental Status Examination and specific evidence of a face-to-face interview.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Performed within 60 days prior to the initiation of requested service.
- Specifies time spent by each examiner if more than one examiner was involved.

COMPREHENSIVE BIOPSYCHOSOCIAL RE-EVALUATION (CBR)

- Summarizes background data, family information, and mental health history.
- Identifies strengths.
- Discusses the impact of the interventions on the child’s current mental health status.
- Contains Mental Status Examination and specific evidence of a face-to-face interview.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Performed within 60 days prior to the continuation of services.
- Specifies time spent by each examiner if more than one examiner was involved.

ADDENDUM TO COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION OR RE-EVALUATION (CBE OR CBR)

- Describes additional information since last evaluation.
- Contains 5-Axis, DSM-IV diagnoses.
- Recommends specific services.
- Contains Mental Status Examination and specific evidence of a face-to-face interview, if completed more than 45 days after the original evaluation.

PLAN OF CARE (ATTACHMENT 6 OR 7)

- Lists all services including school, community resources, DHS, etc.
- Includes specific hours and services requested.
- Dates are concurrent with start date on MA-97.

TREATMENT PLAN

- Addresses issues raised in psychiatric/psychological evaluation.
- Identifies strengths.
- Provides specific interventions to be used.
- Includes progress made on each goal (if re-authorization).
- Is signed by client/guardian and preparer.
- Is signed by DHS representative and/or juvenile probation officer, if applicable.

INTERAGENCY MEETING

- Includes a parent/guardian, behavioral health provider, child (if age 14 or older), representative of DBH/CBH, DHS (if DHS is involved), other agencies involved with the child, and school, if services provided in school.
- Provides summary of discussion, including identification of lead clinician and crisis intervention plan.
- Outlines recommendations for specific services.
- Has signatures of participants agreeing to services (not just sign-in sheet).

SERVICE COORDINATION PLAN - BHRS CASE MANAGEMENT ONLY

- Outlines client's and family's need for case management.
- Outlines specific services to be provided with time frames.
- Includes services that extend beyond completion of BHRS packet.

ATTACHMENT 8 - RESIDENTIAL TREATMENT ONLY

- Includes Interagency Team meeting documentation.
- Is signed by County and DHS, when applicable.

SCHOOL COORDINATION PLAN - BHRS ONLY

- Demonstrates school/agency coordination for classroom-based BHRS.
- Includes statement signed by principal or designee that school agrees BHRS should be provided in the school. If school disagrees, Individual Service Planning Team (ISPT) meeting must be conducted.
- Provides an additional signed statement if child changes schools during the authorized period. Provider must advise CBH of the school change and must submit a signed statement by the new principal or designee that the new school agrees that BHRS should be provided in the new school.



Reminder:

In order to develop an effective treatment plan, the following individuals are strongly encouraged to participate in the **Interagency Meeting**.

- ▶ parent/guardian
- ▶ representatives of other systems involved with the child, i.e., juvenile probation, Department of Human Services (DHS), etc.
- ▶ representatives of the School District of Philadelphia, if the child receives special education services, or if the treatment recommendations would disrupt school placement
- ▶ behavioral health treatment provider
- ▶ the child, if possible (required if age 14 or older)
- ▶ representative of DBH/CBH, when possible

NOTE: Addendums are additions or changes to a completed, comprehensive evaluation based on either the exchange of clinical information or a face-to-face meeting with the client. **Addendums are used when there is an amendment (increase, decrease or change in number or type) to current services.** Addendums **must** be accompanied by the original evaluation or the request will be deemed unacceptable and will be returned to the provider as insufficient documentation.

TIMELINES FOR AUTHORIZATION OF CHILDREN'S SERVICES

Initial requests for children's services must be submitted within 10 business days from the date that the evaluation was completed. Requests for continued BHRS, RCTF, RTF, CRR, Host Homes and partial services must be submitted no earlier than 21 calendar days and no later than 15 calendar days from the last covered day. If parent(s) miss more than three evaluation appointments, providers should contact CBH Member Services, who will provide outreach to the respective families. Contact to CBH Member Services must occur before the provider considers terminating services to the child/family.

Determining Level of Care for Adolescent Substance Abuse

To assist DBH/CBH in determining the appropriate level of care for adolescent substance abuse treatment, credentialed providers of Child/Adolescent Drug and Alcohol services must complete and submit a copy of the **Adolescent ASAM (American Society of Addictive Medicine) Summary Form**.

This form requests specific information about children and adolescents who are currently in or about to be referred to drug and alcohol treatment programs. The **Adolescent ASAM Summary Form** is used to record information on admissions, concurrent reviews and discharges/referrals. To ensure its standardized use, CBH has included the **Adolescent ASAM Summary Form** within this manual and distributed it to all applicable participating CBH providers.

Should providers of Outpatient Child and Adolescent Drug and Alcohol Services submit the Adolescent ASAM Summary Form to CBH?

NO Providers of outpatient behavioral services are no longer required to mail concurrent reviews to CBH. However, because the Adolescent ASAM Summary Form includes a section for concurrent review information, it should be completed and maintained in the client's chart.

Should Child and Adolescent Drug and Alcohol providers of more intensive levels of care, beyond outpatient services, mail the Adolescent ASAM Summary Form to CBH?

YES Providers of Child and Adolescent IOP and Residential 3b and 3c services do need to submit a copy of the Adolescent ASAM Summary Form to:
Director of Clinical Management—CBH, 801 Market Street, 7th Floor, Philadelphia, PA 19107 for review of admissions, concurrent reviews, and discharges/referrals.
Additionally, a copy should be maintained in the client's chart.

Providers with questions or concerns should call CBH Provider Relations at **(215) 413-7660**.

Guidelines for Prior Authorization of Psychological Testing

Psychological Testing employs professionally recognized standardized instruments that have been determined to be useful for a variety of diagnostic and treatment planning purposes. The administration and interpretation of such instruments are regulated by their vendors, the codes of ethics of the mental health professions, and state professional licensing laws. Administration of diagnostic instruments and structured assessment tools should be consistent with all such regulations and guidelines whether the administration occurs as part of a Comprehensive Biopsychosocial Evaluation (CBE) or part of Psychological Testing. Psychological Testing typically involves the administration of a battery of instruments and/or relatively lengthy and/or specialized assessment tools over a concentrated period of time. Psychological Testing must be performed by or under the supervision of an appropriately credentialed psychologist or psychiatrist.

Psychological Testing can be requested when, after completing a CBE, the provider determines that additional diagnostic instruments and structured assessment tools are required to develop an effective case formulation and behavioral health treatment plan. It is the expectation of DBH/CBH that CBEs, complemented by additional Psychological Testing when necessary, will lead to individualized, comprehensive evaluations that determine the treatment needs of individuals. Testing results should be appended to the case formulation, and incorporated into the treatment plan if clinically indicated.

Generally, CBH will consider requests for Psychological Testing under two circumstances:

- 1 Intelligence and/or achievement testing is indicated to inform the behavioral health treatment plan.
- 2 Extended (more than 4 hours) evaluation is indicated to inform the case conceptualization and behavioral health treatment plan. The extended evaluation must utilize diagnostic instruments and structured assessment tools targeted to specific evaluation questions generated by the CBE.

Psychological Testing may also be indicated to address questions that are not primarily related to behavioral health services. Such requests should be directed to the appropriate payor.

For example:

- ▶ Requests for neuropsychological testing to determine organic contributions to behavior should be directed to the member's HMO.
- ▶ Requests in support of educational services should be directed to the member's School District.
- ▶ Requests in support of vocational services should be directed to the PA Office of Vocational Rehabilitation.

Psychological Testing requires prior authorization for reimbursement except if performed by inpatient, residential, or Juvenile Justice System (JJS) providers who have a "bundled" evaluation rate established with CBH. These providers are not eligible for consideration of additional payments for Psychological Testing.

As a medically necessary, specialized, pre-authorized service, Psychological Testing will be supported by CBH for eligible providers when:

- ▶ The requestor is under contract with CBH to provide Psychological Testing.
- ▶ The client or appropriate representative has provided informed consent for Psychological Testing.
- ▶ A legible and complete **Psychological Testing Pre-Authorization Request Form** is submitted and approved by CBH. The **Psychological Testing Pre-Authorization Request Form** should be mailed or faxed to the attention of the **Chief Medical Officer, CBH, 801 Market Street, 7th Floor, Philadelphia, PA 19107; Fax: (215) 413-7111**. The provider will be notified of approval or denial by return fax within two business days.
- ▶ The testing is performed within one month of CBH approval by a licensed psychologist or psychiatrist who participates in the client's treatment team, or an appropriately qualified and supervised non-licensed professional in accordance with Section VIII, Clinical Supervision, of the CBH Credentialing Policy and Procedures Manual.

PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUESTS WILL BE APPROVED WHEN:

- ▶ The request is in support of behavioral health services other than establishing risk for fire setting. CBH will not authorize requests primarily in support of medical/physical treatment/rehabilitation or educational/vocational services in the absence of a specific anticipated impact on the behavioral health treatment plan.
- ▶ The request for testing should describe how the additional evaluation will impact the development of an appropriate and clinically effective treatment strategy.
- ▶ The most recent CBE is appended to the request. The request documents why the CBE is insufficient to determine an appropriate behavioral health treatment plan, or why the current course of treatment is failing.
- ▶ The request indicates by name what tests will be administered, the questions that each test will address, and estimated administration time for each test. Note that estimated testing times that differ significantly from test publisher recommendations should be accompanied by a rationale.
- ▶ The request is signed by a licensed psychologist or psychiatrist and the PA license number is indicated.

A copy of the **approved Psychological Testing Pre-Authorization Request Form** should be placed in the member's clinical record along with test scoring forms, and a report of the testing results. These materials should be made available to CBH upon request.

If a request is denied, and an appeal is requested, the standard Appeals Procedure should be followed.

CBH reserves the right to retroactively disallow reimbursement for Psychological Testing should any audit find non-compliance with the procedures and criteria noted above.

Authorization Guidelines for Out-of-Plan and Out-of-Area Services

An Out-of-Network Referral is a referral made to a behavioral health care provider who does not have a contractual relationship with CBH to provide those services for which the member is being referred. These are generally services not available within the CBH provider network or for clients temporarily residing outside of Philadelphia County.

It is important to understand that while a provider may recommend that a CBH client is in need of treatment services not available in the network, only CBH can authorize treatment of a CBH client by an out-of-network provider. **CBH may refuse to pay for any out-of-network treatment services that have not been prior authorized.**

Guidelines for Obtaining Community Support Services

Providers may obtain a range of community support services on behalf of CBH clients. Unlike other CBH in-plan services, the first three community support services listed below are authorized and coordinated by the Philadelphia County Office of Mental Health (OMH). To obtain prior authorization, call **(215) 599-2150**. Crisis Residence services are authorized by CBH on behalf of its clients. Community Support Services include:

INTENSIVE CASE MANAGEMENT (ICM): ICM is for persons with a major mental illness who may also have significant substance abuse problems. ICM is recommended for persons who experience frequent hospitalizations or times of crisis. These individuals may be unable to obtain or maintain a safe place to live, or to identify, reach, and maintain personal goals. Intensive Case Managers typically meet with clients every 14 days and are available on a 24-hour basis. They generally assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation, and recreation.

RESOURCE COORDINATION (RC): RC is for persons with a major mental illness who may also have substance abuse problems and mild-to-moderate difficulty in social, job-related, or daily living skills. Resource Coordinators typically meet with clients once or twice a month to every other month, depending upon need, and are available during weekday business hours in the event of difficulty. They generally assist clients with obtaining and coordinating community resources, and provide training, support, and assistance with living safely in the community by helping clients maintain stable relationships, housing, and employment.

FAMILY-BASED MENTAL HEALTH SERVICES (FBMHS): The Family-Based Mental Health Program provides a variety of in-home services to children and adolescents with mental health and/or substance abuse disorders and their families. These include traditional therapy services and non-traditional services such as respite services for families, transportation, and linkage with other service systems and community resources. The program assists children who are at risk for psychiatric hospitalization or placement out of the home. It is a short-term program and provides a transition to other community-based programs.

CRISIS RESIDENCES (CR): Crisis Residences provide short-term residence options in a community setting for persons in crisis.

Services That Can Begin Without Prior Authorization but Require an Authorization Number for Payment

There are specific services that the treatment provider may begin to provide without requesting prior authorization. The provider must however, request and obtain an authorization number to receive payment for services. These include:

- ▶ all maintenance psychiatric partial hospitalization services
- ▶ all Intensive Outpatient Provider (IOP) services
- ▶ all initial and follow-up psychiatric consultations
- ▶ all Comprehensive Biopsychosocial Evaluations (CBEs) and Re-evaluations (CBRs)
- ▶ all emergency psychiatric evaluations
- ▶ all court evaluations

The provider should request an authorization number shortly after the episode of treatments begins but no later than 90 days after the date of service. CBH will acknowledge treatment approval of these services by generating an authorization number required for payment. If an authorization number is not requested prior to 90 days or an authorization number is not requested prior to submitting the claim, CBH cannot reimburse the provider.

Guidelines for Authorization of Maintenance Psychiatric Partial Hospitalization Treatment

Maintenance psychiatric partial hospitalization can begin without prior authorization; however an authorization number is required in order to receive payment. Maintenance psychiatric partial is a non-hospital based psychiatric program that provides less than 24-hour care for individuals who are stabilized post-crisis, but require more ongoing, non-acute support than is available in traditional outpatient or aftercare programs. These programs provide an array of services which includes medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental services. Unlike acute partial, the array of services are offered on a longer-term basis and are more related to psychosocial rehabilitation. Individuals often step down from an acute partial program to a maintenance partial as a natural step in the continuum of care, which assists the individual in continuing the progress made in treatment. The goal is to assist with improving the individual's level of functioning in the community.

The Program should submit the **CBH Authorization Request Form – Long-Term Partial** within 90 calendar days after the date of admission or from the start date of the new authorization period. The authorization period will be for 6 months.

Guidelines for Authorization of Intensive Outpatient (IOP) Drug and Alcohol Treatment

IOP services for substance abuse treatment can begin without prior authorization, both for admissions and continued stay, for CBH members and members of Pennsylvania's Behavioral Health Special Initiative (BHSI), which provides services for individuals who have lost or are not eligible for Medical Assistance.

IOP services are provided according to a planned regimen consisting of regularly scheduled treatment sessions 3 days per week, for 5 to 10 hours per week. IOP programs may not provide more than 3 days of IOP services per week unless approved by CBH/BHSI, nor can **the number of clinical treatment hours provided exceed 10 hours per week**. The program should submit the **CBH Intensive Outpatient (D&A) Service Request** form within 90 calendar days after the date of admission or from the start date of new authorization period. The authorization period will be for 4 months.

A person who is not eligible for Medical Assistance may begin IOP treatment under BHSI funding. If the individual is subsequently enrolled in Medical Assistance and transferred to CBH, the IOP episode will be considered one episode. Therefore, once the transfer is made, it will be designated as a "continued stay" and not a new admission. CBH will issue an authorization number for the remainder of the four month time period.

Guidelines for Authorization of Psychiatric Consultations in Medical Facilities

CBH requires that an **Initial Psychiatric Consultation and Follow-up Visits in a Medical Facility** form be completed, after conducting an initial psychiatric consultation and/or follow-up consultation, for all CBH clients in non-psychiatric hospital beds or rehab facilities (medical facilities). The forms should be mailed to the Chief Medical Officer, CBH, 801 Market Street, 7th floor, Philadelphia, PA 19107 within 90 days after the date of the consultation. **Do not submit consultation requests by telephone or fax.**

For a member in an inpatient medical setting, CBH does not require prior authorization for an initial or follow-up psychiatric consultation, as long as:

- ▶ the psychiatric consultation is requested by the attending physician responsible for the patient's care during the inpatient stay, and
- ▶ medical necessity is determined.

CBH reserves the right to retroactively deny payment if a consultation is not deemed medically necessary. The following constitutes Medical Necessity:

- ▶ suicidal ideation, intent or plan
- ▶ homicidal ideation or plan
- ▶ acute agitation
- ▶ chronic and persistent mental illness with concomitant medical illness
- ▶ substance abuse and dependence, including detoxification
- ▶ constant observation needed

- ▶ differential diagnosis and treatment recommendations are requested
- ▶ competency assessment
- ▶ any psychiatric disorder or disturbance that interferes with a patient's care in a medical setting

CBH provides payment for one initial consultation and one follow-up visit.

NOTE: Psychiatric consultations are to be performed **ONLY** by licensed psychiatrists who are independently credentialed by CBH.

Guidelines for Authorization of Comprehensive Biopsychosocial Evaluations and Re-Evaluations

Comprehensive Biopsychosocial Evaluations and Re-evaluations (CBE and CBR) are defined as a complete gathering of ecological information through client interviews, discussion with family members and/or caretakers, review of clinical records, and contact with collaborating agencies that leads to a biopsychosocial formulation, diagnoses, and treatment plan. CBEs are compensated in 30-minute units for up to eight units (4 hours) per evaluation while CBRs are compensated in 30-minute units for up to four units (2 hours) per evaluation. Providers must fully document in the client's clinical chart the date and time (in clock hours) that the CBE/CBR was completed and the specific clinical activities that occurred during each 30-minute unit. The CBE/CBR must also be legibly signed by the clinician who engaged in the clinical activities during that unit.

The request for authorization for CBE/CBR must be submitted after the evaluation has been completed and within 90 days of service provision using the **CBH Outpatient Service Request Form**. Providers must indicate the dates over which the evaluation occurred (cannot exceed 45 days), the number of units being requested, and whether a psychiatrist or a licensed psychologist conducted the evaluation by using the correct level of care code on the CBH Outpatient Service Request Form. While the CBE authorization is generated over a span of dates, each date of service must be billed on a separate claim line. If the evaluation is not completed, it cannot be billed as a CBE but could be billed as one assessment.

Services That Can Begin Without Prior Authorization and DO NOT Require an Authorization Number for Payment

There are specific services that the treatment provider may begin to provide without requesting prior authorization and can receive payment for services without an authorization number. These include:

- ▶ all outpatient mental health and drug and alcohol services, except for Psychological Testing
- ▶ all methadone maintenance clinic services
- ▶ all assessments
- ▶ Crisis Response Center (CRC) evaluations

In order to expedite payment of claims, the provider should request that the case be opened shortly after the episode of treatment begins by submitting a **Case Open Request Form**. Providers must then submit a claim within 90 days of service provision (please allow two weeks for CBH to open a case before submitting a claim for payment).

Guidelines for Extending the Authorization of Treatment Services

The process used to obtain authorization for extended or continuing treatment runs parallel to the one used to obtain the initial authorization. (See the **DBH/CBH Referral and Authorization Process Flow Chart**.) The procedure is as follows:

- ▶ **If initial treatment required prior authorization**, the provider must obtain prior authorization to proceed with extended treatment. The provider must provide the Care Manager with pertinent clinical information that justifies medical necessity for continued treatment. For drug and alcohol programs, providers are required to provide clinical information to support the six dimensions of the PCPC for continued stay.
- ▶ **If initial treatment could begin without prior authorization** but required an authorization number for payment, the provider can again begin providing extended or continuing treatment without prior authorization but must obtain an authorization number by submitting an **Outpatient Service Request Form** within 90 days of service provision.

The Care Management staff at DBH/CBH assess the appropriateness and efficacy of current, extended, and completed treatment through ongoing review. The goal is to ensure that medical necessity criteria are met, that treatment planning is appropriate given the clinical nature of the presenting problem, and that discharge planning occurs as part of the overall treatment process. Utilization review, concurrent review, and retrospective review are all components of the review process.

Discharge Standards

The process of discharge planning is essential to the provision of treatment. It ensures that all appropriate linkages to other levels of care and supportive services are made prior to a client's discharge. There are many types of discharges that can take place, all of which require careful planning and coordination in an effort to ensure, at the very least, the safety of the client (as well as staff) and the continuity of care and support. The following are types of discharges that can take place:

Successful Completion of Treatment

Client successfully completes the treatment program. This includes meeting goals and objectives identified on the treatment plan. Discharge summaries are called in to the Care Manager within 24 hours.

Medical Leave

Client is discharged to a medical facility for treatment of a medical condition requiring immediate attention. Such medical conditions may include an injury requiring emergency room intervention, delivery of an infant, or continued treatment for ongoing acute medical conditions.

Therapeutic Leave

Therapeutic leave assists women who are reuniting with their children and are making the transition from a single women's residential program to one that provides treatment to women with children. It would also benefit adolescents returning home after long-term care whose transition plans include weekend visits with the family.

Transfer to Another Level of Care

In many cases, clients may need to move to a more intensive level of care and/or a specialized level of care that will better address their treatment needs. For example, a client who may begin to present with psychiatric symptoms after being placed into a short-term residential treatment program may require a dual diagnosis program. Or, that client may move from a medically-monitored residential program to an intensive outpatient program and recovery housing.

Guidelines for Coverage of Children in Residential Treatment Programs Requiring Hospital Leave

HOSPITAL LEAVE PROCEDURES

- ▶ If the child is not in the residential treatment program overnight, the facility must inform DBH/CBH of the hospital leave within 24 hours. The facility must document and report this as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

During the Child's Hospital Stay

During hospitalization, the RTF provider must actively coordinate all activities related to the treatment of the child. Coordination activities must include the hospital and the DBH/CBH Care Manager and must be documented in the child's case record at the residential treatment program. When the child is readmitted to the residential treatment program, the facility must develop a new residential service treatment plan that reflects the child's recent hospitalization.

Prior to the Child's Hospital Discharge

- ▶ If the residential treatment services continue to be clinically appropriate for the child upon discharge from the hospital, the residential treatment program must take the child back immediately upon discharge from the hospital.
- ▶ The discharging facility's treating physician or psychiatrist must prepare and submit to the residential treatment program a comprehensive evaluation that includes a recommendation that the child return to the residential treatment program for the balance of the original approved period.
- ▶ DBH/CBH will review the clinical information during the hospital stay. If it is determined that the child's return to the residential treatment program is unlikely, the residential treatment program will be notified and an end date will be determined.

REIMBURSEMENT ISSUES

- ▶ In order to reserve a child's residential treatment program bed when the child leaves for either a general inpatient hospital or a psychiatric facility, CBH will reimburse at one-third (1/3) of the facility's negotiated per diem rate for up to 15 days per calendar year.
- ▶ For this period, the residential treatment program may not accept reimbursement from any other source on behalf of the child.
- ▶ The days during a **hospital leave** can be billed **electronically** or **on paper** and **separately** from the residential treatment billing. The residential treatment program should calculate the units to be **one-third (1/3) of the unit** (not one-third of the rate) for **each** day in the hospital. Providers who use the UB-92 claims forms, should show only the one-third (1/3) calculated units in the Service Units field (Box 46). The hospital stay will be recorded by CBH and used for compliance purposes.
- ▶ The residential treatment program will be reimbursed for less than 15 days if, during the hospital leave, CBH determines that it would not be clinically beneficial for the child to return to the residential treatment program.

Against Medical or Facility Advice (AMA) or Absent Without Leave (AWOL)

A client may choose to terminate treatment voluntarily despite recommendations for ongoing care and intervention efforts by the treatment program staff, Care Management, and CBH Member Services.

When an DBH/CBH client (whether an adult or child) leaves an inpatient or residential mental health or drug and alcohol treatment facility Against Medical Advice (AMA), or is Absent Without

Leave (AWOL), it should be reported as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

Providers must report all significant incidents through a centralized, two-step reporting process. This process covers all DBH/CBH clients receiving in-plan services, as well as those receiving supplemental funding through DBH/CBH.

Providers must take BOTH of the following steps in the event of a AWOL or AMA incident:

1 Report the incident by phone within 24 hours to the CBH Crisis Line **(215) 413-7171**

AND

2 Fax a completed copy of the Significant Incident Report Form within 72 hours (within 24 hours in the event of death or abuse) to DBH/CBH Quality Management at **(215) 413-7132**.

A more detailed outline of this process is contained in the Quality Management section of this manual.

Guidelines for Coverage of Children in Residential Treatment Programs who are Absent Without Leave (AWOL)

Upon discovery that the child is missing, the facility must:

- ▶ conduct an extensive search of the facility buildings, grounds, and off-site areas
- ▶ file a missing persons report with the police
- ▶ notify DBH/CBH
- ▶ notify either the Department of Human Services (DHS) if the child is in its custody or the child's responsible family member and/or legal guardian

REPORTING THE INCIDENT AND DOCUMENTATION

- ▶ When the child is found or returns, the facility must notify all previously notified parties that the child is no longer missing.
- ▶ Each of the above-listed activities must be documented in the child's record.
- ▶ Each notation in the record must be signed and dated upon entry and must give a date, time, and summary of each action taken.
- ▶ Documentation of on-site and off-site searches must specify the date and hours of search, where the search was conducted, any pertinent findings, the date and time of the child's return, and must be signed by staff who conducted the search.

REIMBURSEMENT ISSUES

- ▶ If a child is AWOL, payment will be made by CBH for up to 48 hours that the child is absent **only** if the provider documents in the child's record all attempts that the provider made to locate the child. An absence less than 48 hours will not be compensated if the required reporting does not occur during the above required time frames. The provider will be compensated at the same per diem rate already negotiated with the facility.

- ▶ AWOLs in excess of 48 hours are not compensated and must not be shown as covered days on a claim to the CBH. It is expected that a youth will be readmitted to the facility after a return from an AWOL even if the time away from the facility exceeds 48 hours.

Guidelines for Coverage of Clients in Inpatient Drug and Alcohol Residential Rehabilitation Beds

HOSPITAL LEAVE PROCEDURES

- ▶ The DBH/CBH Care Manager assigned to the non-hospital treatment program will review the clinical information during the client's hospital stay. This will be completed with the treatment program staff member responsible for coordinating care while the client is in the general hospital or a psychiatric facility.
- ▶ During hospitalization, the residential rehabilitation provider must actively coordinate all activities related to the treatment of the client. Coordination activities must include the hospital and the DBH/CBH Care Manager and must be documented in the client's case record at the residential rehabilitation facility.
- ▶ If residential rehabilitation services continue to be clinically appropriate for the client upon discharge from the hospital, the facility must take the client back immediately upon discharge.
- ▶ If the DBH/CBH Care Manager decides that the client's return to the residential rehabilitation is unlikely, the residential rehabilitation facility will be notified and an end date will be provided for billing purposes.
- ▶ The discharging facility's treating physician or psychiatrist must prepare and submit to the residential rehabilitation facility a summary of the treatment and medications provided to the client (if applicable).
- ▶ A drug and alcohol (D&A) assessment is not required for re-entry into the program.
- ▶ When the client is readmitted to the residential rehabilitation facility, the facility must revise the treatment plan to reflect the hospitalization and to identify any changes in goals and objectives. The DBH/CBH Care Manager will record this as part of the continued stay review with the respective substance abuse treatment program.
- ▶ If the client is not in the residential rehabilitation overnight, the facility must inform DBH/CBH of the hospital leave within 24 hours. The facility must document and report this as a **significant incident**. (See section on Quality Management for details on reporting a significant incident.)

REIMBURSEMENT ISSUES

- ▶ In order to reserve a client's non-hospital D&A residential bed when the client enters either a general inpatient hospital or a psychiatric facility, DBH/CBH will reimburse the inpatient non-hospital treatment providers at one-third (1/3) of the facility's negotiated per diem rate for up to 15 days per calendar year.
- ▶ For this period, the D&A facility may not accept reimbursement from any other source on behalf of the client.

- ▶ The residential rehabilitation facility will be reimbursed for less than 15 days if, during the hospital leave, DBH/CBH determines that it would not be clinically beneficial for the client to return to the residential rehabilitation placement.
- ▶ The days during a **hospital leave** can be billed **electronically** or **on paper** and **separately** from the residential rehabilitation treatment billing. The residential rehabilitation facility should calculate the units to be **one-third (1/3) of the unit** (not one-third of the rate) for **each** day in the hospital. The hospital stay will be recorded by DBH/CBH and used for compliance purposes.

Involuntary Discharge

On occasion, clients are involuntarily discharged from services prior to completion of treatment for a number of reasons including non-participation in treatment, lack of therapeutic alliance, or behavioral problems that may threaten the physical safety of staff or other clients. In some cases, those involuntary discharges may have been prevented or issues resolved with appropriate interventions and/or alternative options.

DBH/CBH POLICY REQUIREMENTS REGARDING INVOLUNTARY DISCHARGE

DBH/CBH is committed to fostering a consumer-focused system of care with the goal of providing behavioral health services most appropriate to meet our client's needs. DBH/CBH staff work to ensure that all clients have access to behavioral health services and that there is continuity of care between:

- ▶ levels of treatment
- ▶ levels of supplemental benefits
- ▶ treatment and transition to the community

State requirements mandate licensed treatment providers to review involuntary discharge criteria with clients upon admission into treatment. DBH/CBH in no way condones or supports the involuntary discharge of members without options or interventions being offered to the member. DBH/CBH treatment provider must not conduct involuntary discharge proceedings without the involvement, consultation and review by a team that includes:

- ▶ the treatment provider
- ▶ medical director of the treatment facility
- ▶ CBH
- ▶ OMH/MR
- ▶ CODAAP, including BHSI

This policy of consultation regarding involuntary discharge applies to both in-plan services offered by CBH and supplemental benefits made available through OMH/MR and CODAAP. In-plan services are defined as psychiatric inpatient and outpatient treatment, partial hospitalization, the continuum of substance abuse treatment, children's services, and intensive case management. Supplemental benefits include those services provided through OMH/MR and CODAAP, including but not limited to recovery housing, supportive housing, etc.

It is expected that during the course of treatment and through the authorization process, there is ongoing dialogue between the respective DBH/CBH administrative units including:

- ▶ DBH/CBH Care Manager
- ▶ CBH Member Service Representative
- ▶ OMH/MR—Targeted Case Management Unit
- ▶ OMH/MR—Access to Alternative Services (AAS)
- ▶ Behavioral Health Special Initiative (BHSI)
- ▶ Quality Management Units of DBH

The respective DBH/CBH staff will be involved in defining interventions, alternative options and/or other resolutions that may facilitate continued treatment in the current setting or in an alternative setting. This policy applies to all clients who are active in and attending treatment within DBH/CBH, including those who are Medicaid-eligible and those who are non-Medicaid eligible. The respective staff, such as Member Services, Care Managers, Targeted Case Managers (OMH/MR and BHSI), and OMH/MR Housing Staff are to intervene, when appropriate, at the point that an involuntary as well as voluntary discharge is being considered.

INVOLUNTARY DISCHARGE PROCEDURES

Involuntary Discharges are classified as significant incidents. If an DBH/CBH client, whether an adult or child, is involuntarily discharged from an inpatient or residential mental health or D&A facility, providers must follow the procedures for reporting significant incidents. This procedure is described in the Quality Management section of this manual.

This centralized, two-step reporting process applies to all DBH/CBH clients—those receiving in-plan services, as well as those receiving supplemental funding through the OMH/MR and CODAAP, including BHSI.

In the event of an Involuntary Discharge, providers must take BOTH of the following steps:

- 1 Report the Involuntary Discharge by phone within 24 hours** to the Director of Clinical Management at CBH, **(215) 413-3100**. The purpose of this call is to discuss why involuntary discharge is being considered, to facilitate communication with member/family, and to begin advocacy efforts. The Director of Clinical Management will involve other staff within DBH, as indicated. (In the event that the discharge occurs over a weekend, call the CBH **Crisis Line** at **(215) 413-7171**.)

AND

- 2 Fax a copy of the Significant Incident Report Form within 72 hours** (within 24 hours in the event of death or abuse) to Quality Management at **(215) 413-7132**.

NOTE: For persons who are court-mandated to treatment, the treatment program has the responsibility for requesting court intervention whenever there is a lack of client compliance. The treatment program must notify the court prior to any planned involuntary discharge or at the time of an unanticipated involuntary discharge.

Resolving Disagreements about Treatment Recommendations

If the provider and the DBH/CBH Care Manager do not agree about the level of care or intensity of treatment, the Care Manager will initiate further discussion of the client's needs, presenting symptoms, and the rationale for treatment. If they can then come to an agreement, the agreed upon treatment recommendations will stand.

If an agreement cannot be reached, the Care Manager will present the case to an DBH/CBH Physician Adviser. If the DBH/CBH Physician agrees with the provider's recommendation, the DBH/CBH Care Manager will call the provider and continue the authorization process.

If the DBH/CBH Physician does not agree with the provider, the DBH/CBH Care Manager will inform the provider of the DBH/CBH Physician's recommendation. If the provider agrees with that recommendation, the authorization process resumes. If there is still no agreement, the provider's Attending Physician may request a peer review. Appropriate physician names and phone numbers will be shared at this time. If the physicians come to an agreement, they will inform their respective staff and the process will resume.

If the provider is still not satisfied with the treatment decision, a denial letter will be generated.

Clinical Appeals Procedure

Appeals can occur at three levels. **All appeals must be submitted in writing.**

FIRST LEVEL APPEALS: CBH APPEALS COORDINATOR

- ▶ The provider submits the complete medical record or the BHRS/residential treatment packet for the episode of care in question, along with a statement indicating the wish to appeal the decision, to the CBH Appeals Coordinator. This first level appeal of authorization decision must be submitted no more than 90 days after the end of the episode of care in question.

NOTE: Provider timelines for submission of appeals of authorization decisions will not apply to clients admitted under County Funding whose coverage later converts to CBH.

- ▶ The Appeals Coordinator reviews the case and, if authorization is clearly warranted, will issue the authorization.
- ▶ If the clinical necessity or administrative appropriateness of the care is in question, the Appeals Coordinator forwards the case to an DBH/CBH Physician for review and decision.
- ▶ The DBH/CBH Physician's decision, if not in agreement with the recommendation of the Appeals Coordinator, supersedes the Appeals Coordinator's recommendation in all cases.
- ▶ CBH will notify providers of the result of their first level appeal within 30 days of the receipt of the appeal request.

SECOND LEVEL APPEAL: CBH CHIEF MEDICAL OFFICER

- ▶ In the event the provider disagrees with the appeal decision, the provider may request a second level appeal. Second level appeals should be addressed to the CBH Chief Medical Officer in writing, along with any additional documentation not provided at the time of first level appeals, no more than 30 days from the receipt of notification of the results of first level appeals.
- ▶ The CBH Chief Medical Officer or designee will review the second level appeal and inform the provider of the decision in writing no more than 30 days from the receipt of the second level appeal. If for any reason the CBH Chief Medical Officer was involved in ongoing review or first level appeal review of the case in question, another previously uninvolved DBH/CBH Physician will conduct the second level appeal review.

THIRD LEVEL APPEAL: OMH/MR MEDICAL DIRECTOR

- ▶ Should the provider disagree with the second level appeal decision, the provider may submit a request for a third level appeal. The request for a third level appeal should be directed in writing, along with any additional documentation, to the Medical Director, OHM/MR, no more than 30 days after the receipt of notification of the results of the second level appeal.
- ▶ Third level appeals may be reviewed by the OMH/MR Medical Director or by physicians outside CBH who serve on a panel convened for such purposes (impartiality being the rationale for the panel’s existence).
- ▶ The provider is notified, in writing, of the results of the third level appeal within 15 days of the receipt of the third level appeal.
- ▶ The decision of the third-level reviewer is final.

Denial of Services Notification

CBH clients requesting or receiving services will be notified in writing when services have been denied so that they may have the right to appeal the decision. If Medical Necessity Criteria are not established or met during the initial pre-certification or concurrent review process, and a denial of services is deemed appropriate by the DBH/CBH Physician Advisor, a denial letter is faxed to the client at the facility. Reasons for the denial of requested services will be stated in the letter as well as instructions on the appeals process.

- ▶ For all levels of care, with the exception of BHRS and residential treatment services, denial letters are faxed to the provider who is responsible for giving the CBH client the denial letter.
- ▶ The provider is expected to document clearly in the chart that the denial letter was given to the CBH client. The documentation must include date and time of receipt.
- ▶ It is expected that the provider will assist the CBH client in appealing the decision, with the written consent of the client, if the client so desires. This is not intended to assist providers in appealing decisions based on reimbursement, but to provide CBH clients the right to appeal decisions that further deny treatment.
- ▶ For denials of BHRS and residential treatment services, letters are mailed directly to the client and family, and a notification of denial of services is sent to providers.

FIRST LEVEL APPEALS

- ▶ If a CBH client chooses to appeal the decision, the current authorization will stand until an appeal takes place. A client's treatment will not be disrupted. Chief Medical Officer of CBH or designee will review the request for an expedited review and issue a decision within 24 hours. The provider will ensure that there is no disruption in or change to the level of service being provided to the client while the case is being appealed.
- ▶ In the event that the level of care is denied after the appeal process, DBH/CBH and the provider will work to ensure that there is an appropriate discharge plan in place prior to the client's discharge from the facility.

SECOND LEVEL APPEALS

- ▶ CBH Chief Medical Officer or designee will review the case and issue a decision within 24 hours of the request. The CBH Chief Medical Officer or designee will enter a note into the CBH Information System documenting the date, time, and outcome of the **expedited reconsideration** review.
- ▶ CBH Chief Medical Officer or designee will inform the Care Manager of the results of the expedited reconsideration review. The Care Manager will enter the authorization information consistent with the result of the review, if applicable, and inform the provider.
- ▶ When the request for an expedited reconsideration review occurs after business hours, the Care Manager will contact the DBH/CBH Physician Adviser on call for that day and present the clinical information. The Care Manager will give the DBH/CBH Physician Adviser all information needed to contact the provider directly to review the request.
- ▶ In the event that the DBH/CBH Physician Adviser on call has made the decision to deny the client's request, the Care Manager will refer the request for expedited reconsideration review to the administrative physician on call and follow the above procedures.

THIRD LEVEL APPEALS

- ▶ In the event that a client continues to disagree with the results of the expedited reconsideration review, the case will be referred to the Medical Director of the OMH/MR, with a copy to the Chief Medical Officer of CBH for a third level review. When such requests occur outside of OMH/CBH business hours, the Care Manager will page the OMH/MR Medical Director and review the information.
- ▶ The OMH/MR Medical Director or the CBH Chief Medical Officer will be provided with the information needed to contact the provider to discuss the reconsideration request.
- ▶ The OMH/MR Medical Director and/or the CBH Chief Medical Officer will inform the Care Manager of the date, time, and outcome of the third level reconsideration review. The Care Manager will document the information into the client database along with the authorization information consistent with the second level review decision. This process will also be completed within 24 hours of the receipt of the second appeal.

Resolving Disagreements about Authorizations

Authorization by CBH for in plan behavioral health services takes place in two broad categories: services that require prior approval and an authorization number to begin services and services which do not require prior approval but require an authorization number for billing. There are other services that do not require prior approval or an authorization number in order to bill. (Please see page 3.2 for a listing of services).

Procedure for Services that Require Prior Approval

For services that require prior approval, the provider must contact the assigned Care Manager to resolve any discrepancies no more than 90 days after the date of service. If an agreement cannot be reached between the Care Manager and the provider, the provider must submit a **CBH Authorization Correction Form** to the Director of Clinical Management if the request is being made within 120 days after the date of service or to the Appeals Coordinator if the request is beyond 120 days from the date of service. The Request for Authorization Correction Form must be accompanied by a cover letter that details the nature of the authorization error and the attempts made to get the authorization corrected. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without a review.

Procedure for Services that Do Not Require Prior Approval but Require an Authorization Number

For services that do not require prior approval but require an authorization number for payment, the provider must submit a **CBH Authorization Correction Form** to the Data Entry Supervisor within 90 days of the date of service. Providers will receive the corrected authorization number via an Authorization Letter or Report within four weeks of the date of submission. In the event that an authorization number cannot be corrected as requested, the provider will receive a CBH Outpatient Feedback Form notifying the provider of such.

Request for authorizations that are more than 90 days after the date of service must be submitted to the Operations Coordinator. The request must contain the CBH Authorization Correction Form and a cover letter that details the nature of the authorization error, the attempts made to get the authorization corrected and the reason the request is being submitted past 90 days. The provider will receive a written decision within four weeks of the date of submission of request. Any Authorization Correction Forms that are incorrectly completed or illegible will be sent back to the provider without review.

Procedure for Targeted Case Management and Family-Based Services

Questions regarding authorizations for targeted case management or family-based services should be directed to the Office of Mental Health.

Living Arrangement, Vocational/Educational and Priority Group Codes

All Case Open and Service Request Forms must contain all requested information, including living arrangement, vocational/educational and priority group codes. Forms that do not contain this information will be returned to the provider for completion of any missing or illegible items and delays in this process will not be grounds for late submission appeals.

LIVING ARRANGEMENT CODES

Enter the appropriate number below in the Living Arrangement column of the CBH Case Open, Outpatient, Adult Partial or IOP Service Request Forms.

CLIENT INDEPENDENCE OF LIVING STATUS			
70	Living Independently	74	Restrictive Setting
71	Family Setting	75	Homeless
72	Living Dependently	99	Unknown
73	Supervised Setting		

VOCATIONAL/EDUCATIONAL CODES

Enter the appropriate number below in the Vocational Education column of the CBH Case Open, Outpatient, Adult Partial or IOP Service Request Forms.

CLIENT VOCATIONAL/EDUCATIONAL STATUS			
70	Competitive Employment	74	No Activity
71	Training/Education	99	Unknown
72	Work Program		
73	Meaningful Activity		

PRIORITY GROUP CODES

There are 14 different Priority Groups and a member can have more than one. The Priority Group Codes from which you can choose are as follows:

- ▶ **Adult Mental Health** (Codes: 3, 4, 5, 98 and 99)
- ▶ **Child & Adolescent Mental Health** (Codes 54, 55, 56, 98 and 99)
- ▶ **Drug & Alcohol** (Codes: 60, 61, 62, 63, 64 and 65)

Code	ADULT MENTAL HEALTH
3	ADULT TARGET POPULATION #1: Involuntarily committed anytime in the last year OR a Dx in range of 295.xx, 296.xx, 298.9x or 301.83 AND any of the following:
	Current residence in or discharge from a state mental hospital within last 2 years
	Two admissions to community inpatient psychiatric units or correctional inpatient units or residential services totaling 20 or more days in the last 2 years
	Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years
	1 or more years of continuous attendance in a community MH service (at least 1 unit per quarter)
	History of sporadic treatment—at least 3 missed appointments within the last 6 months, unwillingness to maintain meds regimen or involuntary commitment to OP treatment
	One or more years of treatment for mental illness provided by a Primary Care Provider or other non-MH agency clinician within the last 2 years
	Psychoactive substance use disorder
	Mental Retardation
	HIV/AIDS
	Sensory, developmental and/or physical disability
	Homelessness (sleeping in shelters, cars, parks, abandoned buildings, etc.)
	Release from criminal detention such as jail diversion, expiration of sentence or parole, probation or Accelerated Rehabilitation Decision (ARD)
	GAF below 51
4	ADULT TARGET POPULATION #2: Diagnosis: Any diagnosable mental disorder, except the DSM “V” codes, substance abuse disorders and developmental disorders unless they occur with other serious mental illness
	Functional Impairment: difficulties with basic ADL skills, instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed meds, and functioning in social, family and vocational/educational contexts.
5	ADULT TARGET POPULATION #3: Adults who are statutorily eligible for publicly-funded MH services, but do not meet the criteria for Target Groups 1 or 2.
98	NONE OF ABOVE, BUT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, but are receiving MH services.
99	NOT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, and are not receiving MH services.

PRIORITY GROUP CODES (continued)

Code	CHILD AND ADOLESCENT MENTAL HEALTH
54	CHILD & ADOLESCENT TARGET POPULATION #1: Involuntarily committed anytime in the last year OR MUST MEET ALL OF THE FOLLOWING CRITERIA: Age <18 (or <22, if in Special Ed) AND Within the last year has had a DSM Dx (except MR or psychoactive substance use disorder) AND Receive services from any of the following: • MR • Children and Youth • Special Ed • Juvenile Justice • Health (the child has a chronic health condition requiring treatment) AND Identified as needing MH services by an interagency team, e.g. CASSP committee, Cordero Workgroup
55	CHILD & ADOLESCENT TARGET POPULATION #2: Children at risk of developing a serious emotional disturbance by virtue of any of the following: A parent's serious mental illness OR Physical or sexual abuse OR Drug dependency OR Homelessness OR Referral to the Student Assistance Programs
56	CHILD & ADOLESCENT TARGET POPULATION #3: Children and Adolescents who have had a diagnosable mental illness in the last year (excluding MR, D & A or "V" codes) that resulted in a functional impairment substantially limiting the child's role in family, school or community functioning and who did not meet the criteria for Groups 54 or 55.
98	NONE OF ABOVE BUT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet any of the above MH target group criteria, but are receiving MH services.
99	NOT RECEIVING MH SERVICES: Use this for members involved in the MH system who do not meet the above MH target group criteria, and are not receiving MH services.

Code	DRUG AND ALCOHOL
60	D & A—PREGNANT WOMEN AND WOMEN WITH CHILDREN
61	D & A—INTRAVENOUS DRUG USERS
62	D & A—CHILDREN & ADOLESCENTS YOUNGER THAN 18
63	D & A—THOSE WITH SEVERE MEDICAL CONDITIONS (AIDS, TB, ETC.)
64	D & A—NONE OF THE ABOVE, BUT RECEIVING D & A SERVICES: Use this for members involved in the D&A system who do not meet any of the above D & A target group criteria, but receive D & A services.
65	D & A—NOT RECEIVING D & A SERVICES: Use this for members involved in the D & A system who do not meet any of the above D & A target group criteria, and do not receive D & A services.

SAMPLE DBH/CBH AUTHORIZATION LETTER

Department of Behavioral Health / Community Behavioral Health

AUTHORIZATION LETTER

Date

Provider Name and Address

CBH Assigned Provider ID#

Attention:

Please be advised that today the following services have been authorized for treatment based upon clinical information presented.

Client Name: Name of Client

Client CIS #: Medical Assistance Ten (10) Digit Number

Level of Care: Type and Category of Service

Units: Number of Services Approved for the Specified Period of Time

Authorized Date: Date Authorization Period Begins

Expiration Date: Date Authorization Period Ends

Authorization Number: Number Attached to the Authorization

The provider will contact the assigned Service Manager if additional services are needed. Contact will be on or before the expiration of the previously assigned length of stay. Please notify DBH/CBH if a member has been discharged prior to the date of next review. Thank you.

Sincerely,

Chief Medical Officer

BEHAVIORAL HEALTH REHABILITATIVE SERVICES PACKET SUBMISSION COVER LETTER

CHILD/ADOLESCENT

Date: _____

To: **CBH Clinical Management – BHRS Team**

From: Contact Person _____

Agency _____ CBH Provider # _____

Phone _____ Fax _____

Fax _____

Re: Child/Adolescent Name _____

MA Number _____

DHS: Custody Supervision Name of Worker _____**Type of packet** (please check): Behavioral Health Rehabilitative Services Partial Hospitalization Other (specify): After School and Weekend Program Partial Hospitalization _____

Time Period Requested: _____

Date Interagency Meeting was Held: _____

Type of Evaluation: CBE-MD CBE-Non MD CBR-MD CBR-Non MD Addendum

Name of School Child Attends _____

Address of School _____

Contact _____ Telephone Number _____

Comments: _____

RESIDENTIAL TREATMENT FACILITY PACKET SUBMISSION COVER LETTER

CHILD/ADOLESCENT

Date: _____

To: **CBH Clinical Management – RTF Team**

From: Contact Person _____

Agency _____ CBH Provider # _____

Phone _____ Fax _____

Fax _____

Re: Child/Adolescent Name _____

MA Number _____

DHS Custody Supervision Name of Worker _____**Type of packet** (please check): Residential Treatment Facility Accredited Non-Accredited Room and Board and Treatment Treatment Only Host Homes/CRR

Time Period Requested: _____

Date Interagency Meeting was Held: _____

Type of Evaluation CBE-MD CBE-Non MD CBR-MD CBR-Non MD Addendum

Comments: _____

ADOLESCENT ASAM SUMMARY FORM

Please be as thorough as possible when completing these forms. Thank you.

Date _____ Client DOB _____ Age _____

Provider _____ Provider # _____

Therapist _____ Telephone _____

Client name _____ SS# _____

CIS# _____ Start date _____

Check one: Admission Continued stay Discharge/Referral**I. DSM IV Codes**

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Client's Substance Abuse History (for initial assessment only)

Substance	Age of First Use	Amount/Method	Frequency of Use	Date of Last Use

II. Adolescent ASAM Assessment

1. Please describe any acute symptoms of intoxication or withdrawal that are present. _____

2. Please list client's current medical problems and prescribed medications. Also include information on recent hospitalizations.

3. Please describe the client's emotional and behavioral condition. Please include information on previous psychiatric treatment.

4. Please describe the client's level of acceptance/resistance to treatment. What are the client's motivational factors?

5. Please describe the client's potential for relapse/continued use. What is the client's understanding of relapse? How has the client responded to relapse prevention training? _____

6. Please describe the client's home environment in terms of support for recovery. Please include information on client's social support system. _____

III. Family Behavioral Health History

Please check the type of issues found in patient's family history: D/A MH MR N/A

Please describe the family's mental health and substance abuse history. _____

IV. School: Last grade completed: _____

Please describe education background. Include information on type of school attended and performance/grades.

V. DHS Involvement: DHS involvement: Yes No

DHS worker _____ Telephone _____

VI. Residence: With family Foster Care RTF Alone Other _____

VII: Treatment Recommendations: Please check one.

- LEVEL 0.5 Early Intervention
- LEVEL 1 Outpatient Treatment
- LEVEL 2 Intensive Outpatient Treatment
- LEVEL 3A Medically Monitored Inpatient Detox
- LEVEL 3B Medically Monitored Inpatient Short-term Residential
- LEVEL 3C Medically Monitored Inpatient Long-term Residential

Assessor Signature _____

Date _____

PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUEST

(Please print legibly/type)

Member Name _____ Date of Request _____

MA CIS # _____ Date of Birth _____ Special Ed.? Yes No

Agency name _____ CBH provider # _____ Fax# _____

Requester name* _____ Position/Title _____ Phone# _____

Tester name* _____ Position/Title _____ Phone# _____

**If requester and tester are different people, they must confer prior to submission of this request and both must have direct input to the treatment team.*

Service code? EPSDT/Family Based (400) Non-EPSDT Mental Health (300) Drug & Alcohol (350)

Diagnoses (give complete diagnostic category name including specifiers, if relevant):

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

1. What behavioral health treatment questions will testing address?

2. How will testing impact the treatment plan for this member (be specific about services that will be considered for addition or removal from the treatment package)?

3. What other means (e.g. psychosocial, psychological, and psychiatric evaluations) have been used to answer the above testing questions and why have interviews, observations and record reviews been insufficient to yield an appropriate case formulation and treatment plan for this member at this time?

INITIAL PSYCHIATRIC CONSULTATION AND FOLLOW-UP VISITS IN A MEDICAL FACILITY

Mail this form to: Chief Medical Officer, CBH, 801 Market St. 7th Floor, Philadelphia, PA 19107

Hospital Name _____ Member's Name _____

Psychiatrist's Name _____ Member's Date of Birth _____

Psychiatrist's Tel. _____ Member's CIS # (Pt's MA#) _____

Referring Physician's Name & Tel. _____

Member's SS # _____ CBH Provider # _____ Admission Date _____

Date of Consultation: Initial Consult _____ Follow-Up Consult _____

Reason for Consultation: _____

Diagnostic/findings:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Follow-up care: While inpatient med/surg. Psych hospital _____ (SPECIFY TYPE) Drug & alcohol

Outpatient Partial _____ (SPECIFY TYPE) Other _____ (SPECIFY TYPE) No Follow-Up

Note: Please indicate specific provider _____

Initial recommendation (include specific psychosocial and pharmacologic interventions): _____

.....

CBH INTERNAL USE ONLY

Approved Date _____ Needs Further Action LOC _____

CBH Auth# _____ Date Auth'd _____ Service Manager _____

Comments: _____

SIGNIFICANT INCIDENT REPORT**Fax to Department of Behavioral Health at (215) 413-7132 within 24 hours**

Type of Service: Adult-Mental Health Adult-Substance Abuse Children's
Location of Incident: DBH Residential Outpatient Inpatient PHP Other Day Program
 Other (describe): _____

Consumer Name _____ DOB _____ SS# _____

Consumer Address _____

Date of Incident _____ Time _____ am pm

Location where incident occurred _____

Reporting Agency _____ Agency Provider Number _____

Agency/Program where incident occurred (if other than above) _____

Name, Title, Address, Phone # of person filing report _____

_____ Other Witnesses _____

Indicate Type of Incident (Please Check) *MH only

- | | |
|---|---|
| <input type="checkbox"/> Death | <input type="checkbox"/> Neglect resulting in serious injury or hospital treatment* |
| <input type="checkbox"/> Homicide committed by consumer/client within 3 months of service | <input type="checkbox"/> Arrest for criminal activity |
| <input type="checkbox"/> Suicide attempt requiring medical intervention | <input type="checkbox"/> Fire or serious property damage at a BHS service site |
| <input type="checkbox"/> Violent act by or to a consumer/client requiring emergency medical treatment* | <input type="checkbox"/> Infectious disease outbreak at a BHS provider site |
| <input type="checkbox"/> Alleged or suspected abuse (physical, sexual, financial) of or by a consumer/client* | <input type="checkbox"/> Missing person: child who has not returned home within 8 hours; at-risk adult who has not returned home within 24 hours |
| <input type="checkbox"/> Adverse reaction to medication administered by a provider that requires medical attention* | <input type="checkbox"/> Admin./Involuntary discharge or left AMA or AFA from inpatient, residential rehab. (D&A), children's residence, detox or methadone maintenance |

Summarize the incident. Include precipitating factors, current status, and description of any injuries, medical condition, if applicable

Describe any corrective actions taken to prevent occurrence _____

Pending Investigation? Yes No All pending investigations should be completed & reported within 30 days of event.

Which of the following persons were notified by telephone? Please list name and phone number of persons notified.

Psychiatrist _____ Police _____

Family/Significant Other _____ Fire Dept. _____

Community Treatment Team _____ DHS CHILdline _____

Mental Health Delegates _____ BHSI _____

CASE MANAGER ICM RC D&A _____

Other Agency _____

Signature of person filing report: _____ Date: _____



Claims Submission Policies and Procedures

Increasingly, local, state and federal governments have sought clinical and cost data to more carefully monitor the use of public health care funds. In order to comply with governmental mandates for information, managed care organizations such as CBH have had to request more detailed and complex claims data from providers.

We recognize that this often poses an arduous task. Nevertheless, submission of accurate claims information in a timely manner is an essential part of the provider's role in delivering care, tracking clinical activity and maintaining fiscal stability.

For this reason, CBH is committed to working with providers to help the process go as smoothly and efficiently as possible. We welcome your comments and suggestions on how to further improve the process. In this chapter, we provide general and specific policy and procedural statements pertaining to the submission of claims to CBH. If we can assist you with any additional information, please contact the Claims Department at (215) 413-7125.

Submitting Claims to CBH

Provider shall bill CBH for Covered Services rendered to Enrollees, in the manner specified in this section. Provider shall submit "Clean Claims" no more than 180 days following the date of service for Covered Services requiring an authorization number and no more than 90 days following the date of service for Covered Services not requiring an authorization number. In the event Provider is pursuing Coordination of Benefits, provider must obtain a final determination from the primary payor dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payor. "Unclean Rejected Claims" must be resubmitted as clean claims within the 180-day and 90-day requirements. CBH reserves the right to make no payments for claims received beyond the time requirements stated herein.

Definitions:

CLEAN CLAIM: A clean claim shall mean a claim that can be processed without requiring additional information from the provider of the service or from a third party. A clean claim does not include: claims pended or rejected because they require additional information either from a provider or from internal sources (i.e., claims pended for a determination of third-party liability, etc.); a claim under review for medical necessity; or a claim submitted by a provider reported as being under investigation by a governmental agency, the City of Philadelphia or DBH/CBH for fraud or abuse. However, if under investigation by the City or DBH/CBH, the Department of Public Welfare (DPW) must have prior notice of the investigation.

UNCLEAN REJECTED CLAIMS: An unclean rejected claim shall mean a claim that is returned to the provider or third party for additional information.

CLEAN REJECTED CLAIM: A clean rejected claim shall mean a claim that is returned to the provider or third party due to ineligible recipient or service.

Verification of Eligibility

In order to receive payment for services rendered, providers must check the member's eligibility. Providers can access the DPW's daily eligibility file by phone by calling (800) 766-5387.

Providers may also use the various methods described on DPW's website:

www.dpw.state.pa.us/omap/provinf/omapevs.asp

Coordinating Claims with Authorizations

The authorization process and the claims process are closely related. (See Authorization section for details on the authorization process.) For all services requiring an authorization, the provider will need to obtain an authorization number **prior** to submitting a claim. A claim form without a required authorization number will be rejected. (If filed manually, the claim will be returned.) Providers must submit separate claims forms for each authorization number given for a particular client within 180 days from the date of service.

Non-Authorized Services

All laboratory services (600-level services) and most outpatient services do not require an authorization. When completing the claims forms, these non-authorized services must have a Blanket Authorization Number (BAN) placed in the authorization number field. The BAN for all laboratory services is "0" (zero). Please refer to Schedule A of the Provider Agreement to identify the non-authorized outpatient services and the corresponding BAN. There are sample claims forms at the end of this chapter available for reference.

All other mental health and drug and alcohol outpatient services which do not have a corresponding BAN are authorized services. Continue to follow the authorization process as outlined in the Authorization section of this manual.

Claims must be submitted for those services not requiring authorization within 90 days from the date of service. Any claims submitted after 90 days from the date of service will be rejected for late submission. **The 90-day timeframe includes billing and rejection clean up.** Please note that providers must follow the Case Open Process outlined in Authorization section of this manual.

Pricing and Information Modifiers

Certain services (both authorized and non-authorized) require pricing and/or information modifiers. Please refer to Schedule A to identify the services which require modifiers. When completing claims forms, place the pricing modifier in the first modifier field and the information modifier in the second modifier field. There are sample claims forms at the end of this chapter available for reference.

Entering the Correct Year Format

When completing the UB-92 or CMS 1500 claims forms, the provider must use the complete four-digit year. For example, enter the full year as "2005" rather than "05. Any manual claims submitted without the full year date format will be returned.

Billing for Consecutive Days —“Span Billing”

When billing for **per diem services** that were provided on consecutive days, the provider does not need to enter each individual date of service on the claim form, but may “span bill” the entire period of service. “Span billing” means that the provider notes on the claim the dates that treatment began and ended and the number of units of service provided. For example, if a patient received 5 consecutive days of inpatient treatment, the provider might note January 5 as the “service begin” date and January 10 as the “service end” date.

NOTE: Both the “service begin” date and the “service end” dates must be within the authorization period. The day of discharge from inpatient treatment does not count for units of service.

Billing for Non-Consecutive Days

When billing for non-consecutive days within a particular authorization period, the provider must note each date of service individually. For example, if a client received one hour of outpatient individual therapy on January 3 and one hour on January 5, the provider must bill:

- ▶ Two units of service on January 3 with a “begin date” of January 3 and an “end date” of January 3.
- ▶ Two units of service on January 5 with a “begin date” of January 5 and an “end date” of January 5.

NOTE: Do not span date for non-consecutive days of service or non-per diem services. Such claims will be rejected.

Requirements for Provider Signature

The provider rendering the service must sign all invoices for claims, whether they are submitted manually or electronically. The signature certifies that the service has been rendered according to Medical Assistance (MA) regulations.

METHODS OF SIGNING CLAIMS: The following are acceptable methods of signing claims:

FOR PAPER CLAIMS:

- 1 An actual handwritten authorization signature of the provider directly on the signature line of the invoice. The provider’s initials or printed name are not acceptable signatures.
- 2 A signature stamp of the provider placed directly over the signature line of the invoice is acceptable, if the provider authorizes its use and assumes responsibility for the information in the invoice.
- 3 An actual handwritten authorization signature of the provider directly on the MA-307 Invoice Transmittal Form, a form used to certify that treatment services have been delivered by the provider.

FOR CLAIMS SUBMITTED VIA MODEM, an electronic certification is incorporated into the submission process.

NON-COMPLIANCE: All invoices received that do not meet the provider signature requirements will not be processed. These invoices will be returned to the provider for correction.

Third Party Liability (TPL) Billing

Third Party Liability (TPL) refers to specific entities, such as Medicare, Blue Cross and parties other than CBH that may be liable for all or part of a client's health care expenses. When third-party resources are available to cover behavioral services provided to Medicaid recipients, CBH is the "payor of last resort."

For all services requiring prior authorization, the provider should obtain an authorization number from a DBH/CBH Care Manager prior to submitting a claim. This applies regardless of whether CBH is the primary payor or if it is Medicare or any other insurance carrier. Please also note that providers should obtain authorization numbers at the time clients are admitted to a facility.

Once it is determined that a client has other insurance, the bill should be sent first to the primary insurance carrier(s) for payment consideration. CBH will consider for payment all balances for behavioral health services that are unpaid by the other insurance carriers.

Before CBH can consider a TPL claim for payment, the provider must submit the completed claims form, the Explanation of Benefits (EOB), or the denial letter(s) sent to the provider by any and all other carriers.

The claim must be fully considered and resolved with the primary carrier before it is billed to CBH. If the services are rejected by the primary carrier due to missing, incomplete, or incorrect information, the service must be re-billed to the primary carrier before CBH will consider payment. The EOB, or the denial letter(s) must be the final determination. If the primary carrier rejects the claim, the appeals process must be exhausted with the primary carrier before CBH will consider the claim for payment.

It is important that the provider's bill matches the EOB information. This applies to the billed amount, beginning and ending dates, Medicare approved amount, other insurance paid amount, Medicare deductible and the Medicare co-insurance amount. If the EOB form is larger than letter size, please reduce the EOB to 8-1/2" by 11" in size. Please include a copy of the EOB with each claim. Do not attach several claims to one EOB.

TPL Medicare Inpatient Claims

When submitting Medicare and other insurance carriers' third-party liability claims for one inpatient stay, CBH requires **separate** claims forms for **each** authorization number issued for the various levels of care during the stay. Be sure to use the appropriate authorization number on each claim.

Once you receive your Medicare or other insurance EOB, complete the UB-92 Claims Form for each authorized period. The total of all the claims should equal the total amount billed to the carrier for the entire stay. Also, the billed charges must be for the authorized period. Attach a copy of the EOB to each claim prior to submitting to CBH. It is essential to submit these claims together to ensure proper processing.

Exhausted Medicare Inpatient Lifetime Psychiatric Days

If the member's lifetime psychiatric days have been exhausted, **manually** submit **both** the Medicare Part A and Part B EOBs with the claims form.

The Medicare Part A EOB must show the Medicare Lifetime Exhaustion rejection code. If you do not have the Medicare Part A EOB, you must submit the Medicare Claims Determination letter or the HIQA Inquiry Form from the Medicare system. However, the Medicare HIQA Inquiry Form will only be accepted if the inquiry date is the admission date or the date on which the benefits exhausted during the stay, or should be covered in the Date of Earliest Billing (DOEBA) or Date of Last Billing (DOLBA) time period.

For Medicare Part B, you must use the appropriate value code in Field 39 on the UB-92 Claim Form to indicate the Medicare Part B payment. **The Part B value amount on each claim must reflect only the portion that applies to the dates of services on each claim.**

Post-Payment Recoveries

According to the City of Philadelphia's contract with the Commonwealth of Pennsylvania DPW, CBH is required to take all reasonable measures to ensure that CBH is the payor of last resort when other third-party resources are available to cover the cost of medical services.

When CBH becomes aware of payments made on behalf of CBH clients who have valid third-party resources, post-payment recoveries will be pursued. If a provider is identified as having received an inappropriate payment, a post-payment recovery letter will be sent to the provider. Providers who receive such letters are required to bill the primary carrier(s) and resubmit the claim along with a copy of the recovery letter and the final determination for CBH review and processing.

All cases on which CBH is unable to recover will be turned over to the TPL Unit of the Commonwealth of Pennsylvania DPW.

Member Co-Payment Prohibition

Federal law prohibits treatment providers from requesting co-payments from MA recipients in the Commonwealth of Pennsylvania. Billing CBH members for co-payments for services is also in violation of the CBH Provider Agreement.

Where to Mail Claims

All manual claims must be sent via the U.S. Postal System or delivery service to: CBH, Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Hand-deliveries **will not** be accepted.

Filing Electronic Claims

Filing claims electronically helps providers minimize data entry errors after submission, ensure information is legible, and expedite the processing of their claims. In order to submit claims electronically, the provider must have the appropriate software.

Please refer to the CBH website, www.phila-bhs.org for the necessary information regarding the submission of electronic claims. On the website under “HIPAA Resources,” you will find the following key information:

- Browser Interface Manual
- CBH Companion Guide 837 Professional
- CBH Companion Guide 837 Institutional
- National Implementation Guides

Prior to any initial electronic claims submission to CBH, contact Provider Relations at (215) 413-7660 for specific information needed to create an electronic file and to coordinate the submission of the test file.

Filing Manual Claims

Providers filing manual claims must use one of two printed claims forms designated for that purpose. Please refer to Schedule A for all contractual services and the appropriate CPT codes, pricing and information modifiers, and BANs. This section provides specific information about which forms are to be submitted for the specific types of treatment. It also provides examples of each form.

INPATIENT CLAIMS, UB-92 CLAIM FORM All inpatient hospital or RTF/RCTF-Accredited claims must be submitted using the UB-92 Claim Form. These are the claims forms used in the Pennsylvania MA Program.

OUTPATIENT CLAIMS, CMS 1500 CLAIM FORM All other claims must be submitted using the CMS 1500 Claim Form.

Claims Form Guidelines and Sample Reports

The succeeding section provides specific details on the use of the UB-92 and CMS 1500 Claims Forms. Following is an index:

- ▶ UB-92 Provider Information, Compensable Service and Patient Information.....4.8
- ▶ UB-92 Third Party Liability (TPL) Billing4.9
- ▶ CMS 1500 Patient Information, Provider Name and Compensable Medical Services.....4.11
- ▶ CMS 1500 For Patient TPL Billing Information, Provider Name, and Compensable Medical Services4.12
- ▶ Common Causes for Claims Rejection and Remedies for Providers4.18–4.20

Claims Reports

- ▶ Payment Detail (Sample)4.22
- ▶ Pended Claims Report (Sample)4.23
- ▶ Rejected/Denied Claims Report (Sample)4.24
- ▶ Rejected Claims Report - Previously Pended (Sample)4.25
- ▶ Claims Adjustment Request Form.....4.26

Specific Claims Submission Information

Completion of the UB-92 Claim Form

The UB-92 Claim Form is used when an inpatient (hospital inpatient or RTF/RCTF-Accredited) stay has occurred. **Revenue Codes** are used **exclusively** on the UB-92 claim form. (See **sample UB-92 Claim Forms later in this section.**)

Listed below are the specific fields that must be completed on the UB-92 Claim Form before submitting it to CBH for processing. Remember that all services require an authorization number for billing and only one authorization number per claim form is allowed. **When an item is “not applicable,” do not use a zero. Leave it blank.** See the **PROMISE Desk Chart for Assistance in the Completion of the UB-92 Claim Form** in this section.

UB-92 PROVIDER INFORMATION, COMPENSABLE SERVICE AND PATIENT INFORMATION

Field #	Field Name	Field #	Field Name
1	Provider Name, Address, and Telephone Number	51	Provider Type and Provider MA ID Number (Enter the two-digit Provider Type followed by a slash and the 13-digit Provider MA ID Number)
3	Patient Control Number	54	Prior Payments (if applicable)
4	Type of Bill (See UB-92 PROMISe Desk Chart)	58	Insured's Name (if applicable)
6	Statement Covers Period	59	Client Relationship (if applicable)
7	Covered Days	60	Client's Recipient Number (10-digit MA Number)
8	Non-Covered Days (if applicable)	61	Group Name (if applicable)
9	Coinsurance Days (if applicable)	62	Insurance Group Number (if applicable)
10	Lifetime Reserve Days (if applicable)	63	Treatment Authorization (CBH Authorization Number)
12	Client's Name	67	Principal Diagnosis Code (ICD-9-CM Diagnosis Code)
14	Client's Birthday	76	Admitting Diagnosis (ICD-9-CM Diagnosis Code)
17	Admission Date	82	Attending Physician License Number (Enter the complete license number of the attending physician. This number contains a prefix consisting of two-digit alphabetic characters, the certification number composed of six digits, and a one-letter suffix, or a prefix consisting of two-digit alphabetic characters and the certification number composed of six digits)
18	Admission Hour (See UB-92 PROMISe Desk Chart)	84	CBH Provider Number
19	Type of Admission (See UB-92 PROMISe Desk Chart)	85	Provider Signature or a Signed MA-307 Signature Transmittal Form
21	Discharge Hour (See UB-92 PROMISe Desk Chart)	86	Date Bill Submitted
22	Client Status (See UB-92 PROMISe Desk Chart)		
39-41	Value Codes and Amounts (if applicable)		
42	Revenue Code (See CBH Schedule A)		
43	Revenue Code Description		
46	Units of Service		
47	Total Charges		
50	Payor's Name (Enter the name of each payor organization from which the provider might expect some payment for the bill.)		

UB-92 INPATIENT THIRD PARTY LIABILITY (TPL) BILLING

When using the UB-92 Claim Form for inpatient TPL billing, the fields in the chart below must be completed. The standard fields must also be completed. See **Explanation of the Completion of the UB-92**, sample **UB-92 - Inpatient Third Party (TPL) Claim Form** and **Explanation of Benefits (EOB) for Inpatient UB-92 Third Party Liability (TPL)**. See index for specific page numbers of forms and samples.

UB-92 INPATIENT THIRD PARTY LIABILITY (TPL) BILLING

Field #	Field Name	Field #	Field Name
9	Coinsurance Days (if applicable)	51	Provider Number
10	Lifetime Reserve Days (if applicable)	54	Prior Payment (Enter the covered charges amount on EOB.)
39-41	Value Codes and Amounts (Deductible and coinsurance values, if applicable)	55	Estimated Amount Due (Enter the estimated amount you expect to be paid by CBH.)
50	Payor's name (Enter the name of each payor organization from which the provider might expect some payment for the bill.)		



Also Remember:

When using the UB-92 Claim Form to bill for inpatient services, the following information must be retrieved from the EOB and indicated on the form:

Information To Be Retrieved From EOB	Field No. On UB-92 Claim Form
Service From/Thru	6
Covered Days	7
Co-Insurance Days	9
Lifetime Reserve Days	10
Deductibles	39-41
Covered Charges for billed period	54

Completion of the CMS 1500 Claim Form

The CMS 1500 Claim Form is primarily used for outpatient services.

WHEN TO USE THE CMS 1500 CLAIM FORM

The CMS 1500 Claim Form may be used when filing a claim for the following behavioral health services:

- ▶ outpatient psychiatric treatment
- ▶ non-hospital services (3a, 3b, 3c)
- ▶ outpatient drug and alcohol (D&A) treatment services
- ▶ residential treatment facilities (non-accredited)
- ▶ residential continuum treatment facilities (non-accredited)
- ▶ psychiatric partial hospital programs (acute and maintenance)
- ▶ behavioral health rehabilitation services for children
- ▶ intensive outpatient programs (IOP)
- ▶ consultations
- ▶ methadone maintenance
- ▶ laboratory services

Listed on the chart below are the specific fields that must be completed on the CMS 1500 Claim Form before submitting it to CBH for processing. Never use zeros for items that are not applicable. Leave spaces blank. Refer to the **PROMISE Desk Chart for Assistance in the Completion of the UB-92 Claim Form** and sample **CMS 1500 Claim Form** later in this section.

NOTE: The CMS 1500 Paper Claim Form has room for 6 lines of service, but CBH's claims system can only accept 4 lines of service per claim. Use no more than 4 lines of service on the CMS 1500 Claim Form.

CMS 1500 PATIENT INFORMATION, PROVIDER NAME AND COMPENSABLE MEDICAL SERVICES

Field #	Field Name	Field #	Field Name
1a	Recipient Number (10-Digit MA Number)	19	Provider type and Provider MA ID Number (enter the two-digit provider type followed by a slash and then 13-digit Provider MA ID Number)
2	Recipient Name	21	ICD-9-CM Diagnosis Code
5	Recipient Address	23	Prior authorization number (CBH authorization number or BAN number)
9	Other insured's name (Another health insurance secondary to insurance in block 11)	24a	Dates of service (please note begin and end date)
9a	Other insured's policy number (if applicable)	24b	Place of service (see PROMISe Desk Chart)
9b	Other insured's date of birth (if applicable)	24d	Procedure code (pricing modifier and/or info modifier, if applicable) (See OBH/CBH Schedule A)
9c	Employer's name or school name	24f	Usual charges
9d	Insurance plan name or program name (other than MA)	24g	Units of Service
11	Primary Insurance (other than MA) policy number (if applicable)	24j	COB/Resource Code (if applicable) (Enter the one-digit resource code, which is found in the PROMISe Desk Chart, if the recipient has another resource available to pay for the service before billing MA)
11a	Insured's date of birth (if applicable)	24k	Other insurance paid or Medicare payment (if applicable)
11b	Employer's name or school name (if applicable)	28	Total charges (Enter the total sum of 24f, 1 thru 4 in dollars and cents)
11c	Insurance plan name or program name (if applicable)	29	Amount paid (Enter the total sum of 24k, 1 thru 4 in dollars and cents)
12	Recipient signature and date (all invoices must have either the recipient's signature or the "signature exception" or "signature on file")	31	Signature of physician, signature stamp or MA-307 Transmittal Form
17	Name of referring/supervising/attending practitioner or prescriber		
17a	Referring practitioner's or prescriber's license number (enter the complete license number of the practitioner noted in 17). This number contains a prefix consisting of two alpha characters, the certification number composed of six digits and one alpha suffix. For provider type 8 (Outpatient D&A Clinic), 11 (Outpatient Psychiatric Clinic), and 11 (Psychiatric Partial Hospital Facility), enter the 13-digit MA ID number of the practitioner noted in 17.		

CMS 1500 THIRD PARTY LIABILITY (TPL) BILLING

When completing the CMS 1500 Claim Form for TPL billing, the following fields **must be** completed. The standard fields must also be completed as described above under **Explanation of the Completion of the CMS 1500 Claim Form**. See index for page number of sample **CMS 1500 - Outpatient Third Party Liability (TPL)**.

**CMS 1500 FOR PATIENT TPL BILLING INFORMATION,
PROVIDER NAME, AND COMPENSABLE MEDICAL SERVICES**

Field #	Field Name	Field #	Field Name
9	Other insured's name (Another health insurance secondary to insurance in block 11)	24f	Usual charges (The amounts should agree with the other plan's EOB)
9a	Other Insured's Policy or Group Number (if applicable) (other than MA)	24j	COB/Resource Code (if applicable) (Enter the one-digit resource code, which is found on the PROMISe Desk Chart, if the recipient has another resource available to pay for the service before billing MA)
9b	Other Insured's Date of Birth (if applicable)		
9c	Employer's Name or School Name (if applicable)	24k	Medicare or Other Insurance Paid (if applicable) (Enter medicare or the portion of the bill that was paid by another insurance company in this block)
9d	Insurance Plan Name or Program Name (if applicable) (other than MA)	28	Total Charges (Enter the total sum of 24f 1 thru 4 in dollars and cents)
11	Primary Insurance (other than MA) policy number (if applicable)		
11a	Insured's date of birth (if applicable)		
11b	Employer's name or school name (if applicable)		
11c	Insurance Plan Name or Program Name (other than MA)		
		29	Amount paid (Enter the total sum of 24k in lines 1 thru 4 in dollars and cents)

REMINDER: *When billing for payment of Medicare deductibles and/or coinsurances for services covered by MA, the provider must use the appropriate MA Procedure Code.*

Processing Payments

When a provider submits a claim to CBH, it goes through several stages of review and processing, described below:

Claims Processing Cycle

ADJUDICATION PROCESS: CBH will adjudicate 100% of clean claims within 45 days and adjudicate 100% of all claims within 90 days. Adjudicate means to pay or reject a claim.

PAYMENT OF CLAIMS: Payment will be mailed in the form of a check to the address designated by the provider in the provider agreement. Changes in address must be reported in writing under the signature of the CEO to CBH, Provider Operations, 801 Market Street, 7th Floor, Philadelphia, PA 19107.

CLAIMS REPORTS: Whether a claim is accepted, rejected or pended, claims reports will be made available to the provider explaining the reasons for the action taken on the claim. (Learn more and see samples in the following section under **Claims Reports**.)

Claims Adjustments

On occasion, after a payment has been issued, either CBH Claims staff or the provider may detect an error in the amount that was paid. The adjustment process deals with the correction of those claims that have been through the adjudication cycle and been paid. If a claim has been rejected and **not yet paid**, it is not subject to an "adjustment." Only those claims that have already been paid can be adjusted. Claims adjustments generally occur for the following reasons:

- ▶ Claim was submitted and paid twice.
- ▶ Claim was paid at wrong rate.
- ▶ Claim was paid for the wrong date(s) of service.
- ▶ Claim was paid at wrong level of care. (Claims Department will only reverse the claim that was paid for the wrong level of care. It is the provider's responsibility to obtain the new authorization and submit the claim.)
- ▶ Claim was submitted with excessive units of service within time period.
- ▶ Services were span billed with overlapping days on more than one claim.
- ▶ A Compliance audit was conducted.

Adjustments must be received within 180 days from the date of service for services requiring an authorization and no more than 90 days from the date of service for services not requiring an authorization. In the event a provider is pursuing coordination of benefits, the provider must obtain a final determination from the primary payor date no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payor. See the **Claims Appeal Process** for adjustments that CBH will not accept within these timeframes.

Submitting Adjustments For Manual Claims

Complete and submit the following:

- ▶ a **Claims Adjustment Request Form**
- ▶ a copy of the corresponding Payment Detail Report, clearly indicating the claim line requiring adjustment.
- ▶ a Corrected Claim(s) Form
- ▶ the EOB for TPL Claims

Submitting Adjustments For Electronic Claims

Complete and submit the following:

- ▶ a **Claims Adjustment Request Form**
- ▶ a copy of the corresponding Payment Detail Report, clearly indicating the claim line requiring adjustment.

Providers submitting claims electronically via modem must wait to receive a Payment Detail Report containing reversals of the erroneous payments from CBH before resubmitting a claim. This will confirm that the necessary adjustments have been made, allowing the resubmitted claims to be processed correctly.

The top two copies of the Claims Adjustment Request Form must be mailed with the appropriate support documents to: CBH, Claims Department, Attention: Adjustments, 801 Market Street, 7th Floor, Philadelphia, PA 19107.

If you have specific questions regarding an adjustment or need additional copies of the Claims Adjustment Request Form, contact the Provider Claims Hotline at (215) 413-7125.

Pended Claims

Pended claims are those claims that are put on temporary hold to assure that CBH is the payor of last resort for members that have other primary coverage in addition to MA. It also determines if the services are covered by a third party payor. TPL Claims will pend when:

- 1 The provider indicates on the claims form that the member has another coverage.
- 2 The provider submits an EOB along with the claim.
- 3 During the processing of the claim, CBH's eligibility file, as transmitted by the Pennsylvania DPW, indicates that the client is covered by other insurance.

The provider will receive a Pended Claims Report listing those claims that have pended after the adjudication process. (See page 4.24 for more information about this report and page 4.26 for a sample "Pended Claims Report.")

To avoid disruptions to treatment of children, BHRS claims will first pend, but will be released for payment by CBH within two weeks.

Rejected/Denied Claims

CBH may reject or deny a claim for a variety of reasons. In some cases, crucial claims information, such as dates, authorization numbers or client information, may be missing or incorrect. In addition, the provider may not have submitted the claim to the primary payor.

When rejecting a claim, CBH will send the provider a Rejected/Denied Claims Report listing those claims that have been rejected/denied after the adjudication process. (See "Claims Report" section for more information and a sample of this report.)

When a claim has first pended and then been rejected, CBH will mail the provider Rejected Claims Previously Pended Report. (See "Claims Report" section for more information and a sample of this report.)

Providers are encouraged to carefully review the original claims, the Rejected/Denied Claims Reports, and the Rejected Claims Previously Pended Reports from CBH and to make any necessary corrections or revisions, and when appropriate, resubmit the claims for payment.



One of the most common causes for claims to be rejected is entering date information incorrectly. When entering inpatient treatment days, please enter the date of admission as the "begin date" and the day of discharge as the "service end" date, but count the length of the stay according to the number of "nights" of stay. The day of discharge is not counted as a day of treatment.

Claims Appeal Process

There are three categories of claims rejections that providers may appeal. The processes for each category are described separately.

APPEALING REJECTED CLAIMS FOR THIRD PARTY LIABILITY (TPL) CAUSED BY DISCREPANCIES BETWEEN THE ELIGIBILITY VERIFICATION SYSTEM (EVS) AND THE DBH/CBH CLAIMS SYSTEM

If the provider accesses the EVS information and it indicates that the client does not have a TPL coverage, but during processing of the claim, the CBH system detects such coverage and consequently rejects the claim within 180 days from the date of service for services requiring an authorization and within 90 days from the date of service for services not requiring an authorization, the provider must do the following:

- 1 Make a copy of the rejection report that notes the TPL rejection.
- 2 Make a copy of the eligibility information that notes the client does not have TPL coverage.
- 3 Make a copy of the claim along with any other evidence of non-coverage by a third party.
- 4 Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope "TPL Discrepancy."

CBH will then perform a manual review of the client's coverage. If it is determined that the client has no TPL coverage, CBH will reprocess the claim and make the necessary system adjustments. If it is found that the client does have TPL coverage, CBH will return the claim to the provider along with

the name of the primary carrier and policy number. The provider must obtain a final determination from the primary payor dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of the final determination from the primary payor.

APPEALING REJECTED CLAIMS FOR “RECIPIENT NOT ELIGIBLE” CAUSED BY DISCREPANCIES BETWEEN THE EVS AND THE DBH/CBH CLAIMS SYSTEM

If the provider accesses the eligibility information and it indicates that the client is eligible for treatment on a particular date, but during the processing of the claim CBH does not show the individual to be eligible and rejects the claim, within 180 days from the date of service for services requiring an authorization and within 90 days from the date of service for services not requiring an authorization, the provider must do the following:

- 1 Make a copy of the rejection report that notes the eligibility rejection.
- 2 Make a copy of the eligibility information that notes the client was CBH eligible to receive service on the date(s) indicated on the claim.
- 3 Prepare a new clean claim for the service(s) performed.
- 4 Mail the above to the CBH Claims Department, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope “**Eligibility Rejection Appeal.**”

The claims will be handled by CBH in one of the following ways:

- ▶ If the claim was rejected within the last month, it will be overridden and appear on the next Payment Detail.
- ▶ If the claim rejection is older than one month, it will be re-rejected first. The provider will get another Rejection Report after the next adjudication, indicating the same rejection reason. However, this time, the abbreviated word “Elig”, will appear in the column entitled, “Patient’s Reference Number.” Following the adjudication, the rejection will be overridden and appear on the next Payment Detail. While this process is cumbersome, it is necessary to maintain the integrity of our reporting to the Pennsylvania DPW.

NOTE: The override for eligibility applies only to claims that were submitted and rejected for “**Recipient Not Eligible.**” It does not apply to authorization requests that were denied because of ineligibility.

APPEALING CLAIMS FOR LATE SUBMISSION

If CBH receives a claim or Adjustment Request Form more than 180 days from the date of service for services requiring an authorization, or more than 90 days from the date of service for services not requiring an authorization, the claim or adjustment form will be rejected or returned to provider due to late submission. Claims or adjustments rejected or returned for late submission may be appealed **only** due to processing errors made by CBH. The following requirements are necessary in order to be eligible for appeal:

- 1 Provider had submitted a clean claim within the required timeframes (no more than 180 days from the date of service for services requiring an authorization or no more than 90 days from the date of service for services not requiring an authorization).
- 2 CBH had improperly processed the clean claim causing an incorrect payment or a rejection **only** resulting from CBH's processing error.
- 3 Provider resubmits the clean claim (along with an Adjustment Request Form for incorrect payments) within 90 days from the date of the incorrect payment or rejection.

The following information must be submitted with the clean claim (and Adjustment Request Form, if applicable):

- 1 A letter addressed to the Claims Appeals Specialist indicating the specific cause of the rejection or incorrect payment due to CBH's error,
- 2 A copy of the rejection report that notes the rejection reason caused by CBH's error or a copy of the payment detail that notes the incorrect payment made due to CBH's error, and
- 3 A copy of the EOB for TPL claims, if applicable.

Mail the appeal to the attention of the CBH Claims Appeals Specialist, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Clearly write on the envelope "**Claims Appeal.**"

The following chart lists the most frequent causes for claims to be rejected and the remedies for providers.

COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS

Rejection Description	Cause	Remedy
Claim line was previously paid.	<p>1. If exact same date(s) of service(s) for same person was previously paid, claim will reject.</p>	Check to ensure no data entry error was made.
	<p>2. When a provider submits two claims for separate units of service within the same billing period, the second claim will reject if the first claim form has referenced the entire billing period. (For example, a provider has authorization for 30 units from 1/1/05 to 1/31/05. Claim #1 is submitted for 15 units used on 1/1 to 1/15, but references 1/1 to 1/31 on the claim form. If a second claim is submitted for the remaining 15 units with service dates 1/16 to 1/31, the second claim will be rejected because it is covering a period that was already paid, and therefore appears to the system to be an overlapping bill.)</p>	Submit a Claims Adjustment Request Form for the initial claim indicating that only a portion of the entire billing period and units of service were used. Also resubmit a corrected claim reflecting the entire billing period.
No units of service left for this authorization	<p>1. This may occur when all authorized units were paid, and the provider submitted a claim for additional units.</p>	Check to see if the additional date(s) of service for additional units are under another authorization number. If so, re-submit the claim using the correct authorization. If additional units are needed for the same individual, the DBH/CBH Care Manager must approve extending the authorization. Then provider can resubmit claim for the added units. Or, new authorization may be issued and provider can re-submit the claim with the correct authorization for payment.
	<p>2. If the initial authorization was zeroed out or canceled, the claim will be rejected for this reason.</p>	
Invalid or unknown recipient ID number.	If a claim was submitted with the wrong recipient number or no number, the claim will reject.	Check to ensure no data entry error was made. Re-submit with the correct CIS number.
Recipient was not eligible for service on a specified date.	These claims have been rejected because, according to DBH/CBH records, the client was not eligible for service on that date.	Re-submit with proof of eligibility. Attach eligibility information for that date of service for correct processing. Send claims to the attention of: "Eligibility Rejections."
Billed dates of service do not match authorized dates of service	If a claim is submitted for service dates outside the authorization period, this error will appear. (For example if the authorization period is for 1/1/05 to 2/1/05 and the claim submitted is for 2/5/05, the claim will be rejected.)	Check the authorization report for the correct authorization number for this date of service. Re-submit the claim for the correct period or obtain a corrected authorization.

COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS

Rejection Description	Cause	Remedy
Invalid primary ICD-9 Behavioral Diagnosis Code.	Diagnosis code is not considered valid by DBH/CBH, was not correctly entered, or was missing on the claim.	Use the correct ICD-9 code number for proper payment. Contact Provider Relations if you need assistance at (215) 413-7660.
Invalid or unknown authorization number	The claim was submitted either with no authorization number, an incorrect authorization number, or no BAN.	Check to ensure no data entry error was made. Re-submit with correct authorization number or BAN.
Client is not the same as client referenced in authorization	This rejection will typically appear when the client named in the claim form is not the same as the client named on the authorization. This rejection will also appear with the "Invalid or unknown recipient number," and with "Invalid or unknown authorization number."	Refer to authorization report to check for accuracy of client number or authorization number.
Provider is not the same as provider of authorization referenced	Provider number billed is not the same as the one referenced in the authorization.	Re-submit with the correct provider number that was authorized, or request that the authorization be changed.
Service is not the same as service of authorization referenced	Service is not the same as the service referenced in the authorization. Claim report will indicate wrong service was used. (The claim was submitted with the incorrect authorization or the incorrect cpt or revenue code.) This rejection will also appear with "Invalid or unknown authorization number."	Re-submit with the correct authorization or the correct cpt or revenue code.
Claim is no longer eligible for payment: late submission.	Claim is submitted beyond the 180 days of date of service for Covered Services requiring an authorization and beyond the 90 days of date of service for Covered Services not requiring an authorization.	Refer to Claims Appeals Process section of manual.
Unknown or invalid case number.	Case is not opened.	Reference Case Open Process in Authorization section of this manual.
Cannot match provider to service for specific date	Discrepancy in the contract for that level of care	Contact Claims Department for clarification at (215) 413-7125.

COMMON CAUSES FOR CLAIMS REJECTION AND REMEDIES FOR PROVIDERS

Rejection Description	Cause	Remedy
<p>Cannot find unique service for CPT code (not required authorization)</p> <p>Incomplete level of care data to determine edit rules</p> <p>Insufficient information to calculate level of care</p>	<p>These three errors result from not following Schedule A, specifically:</p> <ol style="list-style-type: none"> 1. Submitting a claim with the wrong CPT code 2. Invalid or no BAN 3. Invalid or no information modifier 4. Invalid or no pricing modifier 	<p>Resubmit claim with the correct information.</p>
<p>Units served exceeds maximum allow PAID units per day</p>	<p>Primarily results for the following reasons:</p> <ol style="list-style-type: none"> 1. When a claim is already paid for that date 2. When a claim is submitted with more than the clinically allowable units per day 	<p>Verify the same date of service was already paid. Contact Provider Relations if you need assistance at (215) 413-7660.</p>
<p>Unknown HIPPA error CPT code (not in table consmar3)</p>	<p>Results from not following Schedule A, specifically when claim is submitted with the incorrect CPT code.</p>	<p>Resubmit with the correct CPT code.</p>

Claims Reports

The following are brief summaries and examples of reports generated for providers. Samples follow.

- 1 The **Payment Detail Report** lists all paid services with the accompanying check. There are no totals for each individual but there is a grand total for the total number of units paid and the total dollar amount paid.
- 2 The **Pended Claims Report** documents the claims that have been adjudicated and “pended” or held while waiting for review by CBH’s TPL Department. The only reason for a pended claim is the existence of Third Party Liability (TPL). TPL refers to another payor (e.g., Medicare, Blue Shield) having a financial responsibility for payment for all or part of the claim.
- 3 The **Rejected/Denied Claims Report** refers to all claims that will not be paid by CBH as submitted. It lists warnings and the reasons for denials and rejections along with their corresponding amounts. It also lists claims that are shown on the **Rejected Claims Previously Pended Report** but will only show the pended and warning reasons. You must refer to the **Rejected Claims Previously Pended Report** to find out why a pended claim was rejected.
Some of the claims may be resubmitted with the appropriate information while others will not be paid at all. Please review the reason for the rejection/denial to determine whether or not to resubmit the claim.
- 4 The **Rejected Claims Previously Pended Report** lists those pended claims that were subsequently rejected by CBH. This report also instructs the provider to resubmit the claim with an EOB or to make other corrections before resubmitting the claim. Claims with EOBs attached cannot be processed electronically; send a paper copy of the claims form and EOB.

Payment detail and rejections (including rejected claims previously pended) are available electronically via EDI Browser.

NOTE: For help in understanding your rejected claims report, see **Common Causes for Claims Rejection and Remedies for Providers**.

PAYMENT DETAIL (Sample)

Department of Behavioral Health/Community Behavioral Health
MASTRR-MCARE
PAYMENT DETAIL

03/10/2005
02:19:27
User: OPERATOR, REPORT

Date Paid: 12/12/99
Selection Criteria: For All Providers
Provider Name: Get Well Soon, Inc. (123456)

Client Number	Client Name	Service Dates	Procedure Code	Billed Amount	CBH Claim Number	Provider Claim Num	Authorize Number	Level of Care	Paid Units	Amount Paid
0012345678 1/5/2005	JOHN DOE 1/5/2005 90804				123456	DOEA/1		INDIVIDUAL THERAPY W/PSYCHIATRIST	2	90.00
0012345678 1/17/2005	JOHN DOE 1/17/2005 90804				123456	DOEA/1		INDIVIDUAL THERAPY W/PSYCHIATRIST	1	45.00
0087654321 1/7/2005	MARY JONES 1/7/2005 90805				654321	JONES		INDIVIDUAL THERAPY W/PSYCHIATRIST	1	45.00
0087654321 2/2/2005	MARY JONES 2/2/2005 90804				654321	JONES		INDIVIDUAL THERAPY W/PSYCHIATRIST	2	90.00

Provider Name

CBH Assigned Provider Number Used by Providers to Bill for Services

Client's CIS Number

Client's Name

Service Date

CBH Claim Number

Provider Claim Reference Number

Description of Service (listed as "Level of Care")

Number of Units Being Paid

Dollar Amount Paid

CBH Authorization Number (as listed on the Authorization Letter)

Procedure Code used to Bill

REJECTED CLAIMS REPORT - PREVIOUSLY PENDED (Sample)

Department of Behavioral Health/Community Behavioral Health
MASTRR-MCARE
Name of Report
REJECTED CLAIMS REPORT (PREVIOUSLY PENDED CLAIMS)
Adjudication Period
Reported for the period from: 11/10/2005 through 11/13/2005

12/15/2005
13 : 42 : 51
User: OPERATOR REPORT
Provider Name
CBH Assigned Provider Number Used by Providers to Bill for Services
Selection Criteria: For All Providers For All Clients
Provider Name: Get Well Very Soon, Inc. 123456

Authorization Number
Level of Service
Description
Invoice Number
Line #
TPL Stat
Billed Dollars
Units
Adjudicated Date
Provider Ref #
Received Date

Client Name	Client's CIS Number	Authorization Number (as listed on the authorization letter)	Description of Service (listed as "Level of Service")	CBH Invoice Number	TPL Stat	Billed Dollars	Units	Adjudicated Date	Provider Ref #	Received Date
Client Name: Doe, John 00112345678 201010 41	Resubmit other ins. EOB			1366302	No	85.00	1.00	10/12/2005	Doe90	10/27/2005
201010 41	Resubmit other ins. EOB			1366302	No	85.00	1.00	10/12/2005	Doe90	10/27/2005
Totals for Client:						170.00	2.00			
Client Name: Jones, Mary 0087654321 69	INDIV. THERAPY NON-PSYCHIATRIST COB payment>CBH max allowance			153931	Yes	125.00	1.00	10/12/2005	Jones47	10/27/2005
69	INDIV. THERAPY NON-PSYCHIATRIST COB payment>CBH max allowance			153986	Yes	125.00	1.00	10/12/2005	Jones47	10/02/2005
Totals for Client:						250.00	2.00			
Totals for Provider:						420.00	4.00			

CLAIMS ADJUSTMENT REQUEST FORM

Please Print

Requestor's name _____ Date submitted _____

Provider name _____

MA ID # _____ Authorization # _____

Recipient Name _____ Recipient ID # _____

Corrected Claim (check one box) paper (attach) diskette (attach) via modem

Reason for Adjustment: (please check applicable box(es), attach payment detail and corrected claims)

- Duplicate authorization (claims submitted and paid twice)
- Payment made at wrong rate
- Payment made for incorrect level of care
- Payment made for excessive units of service within a time period
- Service was span billed with overlapping days on more than one claim, resulting in payment for the first claim submitted, but rejections for subsequent claims
- Other (please explain) _____

ADJUSTMENT DETAIL

	Current	Should Be
Level of Care Code	_____	_____
Date(s) of Service	_____	_____
Units Paid	_____	_____
Rate Paid	_____	_____

(completed by CBH only)

Adjustment Request is being returned because:

- Units exhausted Missing or incomplete claim form Missing Payment detail
- Other _____

Return the top two copies of this form with required support materials to:

CBH Claims Department (Attention: Adjustments) • Community Behavioral Health
 801 Market Street, 7th Floor • Philadelphia, PA 19107

For more information or additional copies of this form, call CBH Provider Relations at (215) 413-7660



Sample Forms

The succeeding section provides reference materials as well as samples of claims forms and reports:

- ▶ **PROMISe Desk Chart for Assistance in the Completion of the UB-92 Claim Form**4.28–4.29
 - ▶ UB-92 – Inpatient Claim Form4.30
 - ▶ UB-92 – Inpatient Third Party Liability (TPL) Claim Form4.31
 - ▶ Explanation of Benefits (EOB) for Inpatient UB-92 Third Party Liability (TPL)4.32

- ▶ **Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) Desk Reference**.....4.33–4.35
 - ▶ OMHSAS Desk Reference - Provider Types4.33–4.34
 - ▶ OMHSAS Desk Reference - Modifiers.....4.34
 - ▶ OMHSAS Desk Reference - HIPAA Place of Service Codes4.35

- ▶ **Assistance in the Completion of the Outpatient and CMS 1500 Claim Forms**4.10–4.12
 - ▶ CMS 1500 - Outpatient Claim Form4.36
 - ▶ CMS 1500 - Outpatient Third Party Liability (TPL) Claim Form.....4.37
 - ▶ Explanation of Benefits (EOB) for CMS 1500 Outpatient Third Party Liability (TPL)4.38

PROMISE DESK CHART FOR ASSISTANCE IN THE COMPLETION OF THE UB-92 CLAIM FORM

Code	Code	Code
PROVIDER TYPE FIELD #2		
1 General hospital	1 Private psychiatric hospital or psychiatric unit	1 Accredited residential treatment facility or extended acute psychiatric care unit (inpatient)
1 Medical rehab hospital, medical rehab unit, D&A hospital or D&A unit	1 Public psychiatric hospital	
TYPE OF BILL Field #4		
1 Admit through discharge	7 Replacement of prior claim	8 Void/cancel prior claim
2 Interim—first claim		
ADMISSION AND DISCHARGE HOURS Field #18, 21		
00 12:00 midnight–12:59 am	TO	23 11:00 pm–11:59 pm
TYPES OF ADMISSION Field #19		
1 Emergency	3 Elective	2 Urgent
SOURCE OF ADMISSION Field #20		
5 Transfer from LTC facility		
PATIENT STATUS Field #22		
01 Routine discharge	04 Discharge/transfer to ICF	07 Left against medical advice or discontinued care
02 Discharge/transfer to another general hospital for inpatient care	05 Discharge/transfer to another type of institution for inpatient care or referred for outpatient services to another institution	20 Expired
03 Discharge/transfer to SNF		30 Still a patient
CONDITION CODES Field #24-30		
02 Condition is employment related	X2 Medicare EOMB on file	Y0 Newborn eligibility
03 Patient covered by insurance not reflected here	X3 Hysterectomy acknowledgement form	Y1 Family planning
05 Lien has been filed	X4 Medicare denial form	Y2 Pregnancy
60 Day outlier	X5 Third-party payment on file	Y3 Co-pay not collected
77 Provider accepts or is obligated/required due to contractual arrangement or law to accept payment by a primary payor as payment in full	X6 Restricted recipient referral form	Y4 Medicare benefits exhausted
	X7 Medical documentation for hysterectomy	
X0 Abortion physician certification	X8 Administrative waiver	Y6 Third-party denial on file
X1 Sterilization patient consent form	X9 Patient pay applied to previous claim	

(continued on next page)

PROMIS_e DESK CHART FOR ASSISTANCE IN THE COMPLETION OF THE UB-92 CLAIM FORM (continued)

Code	Code	Code
OCCURRENCE CODES Field #32-35		
01 Auto accident	05 Other accident	25 Date benefits terminated by primary payor
02 No-fault insurance involved—including auto accident/other	06 Crime victim	A3 Benefits exhausted
03 Accident/tort liability	24 Date insurance denied	B3 Benefits exhausted
04 Accident/employment related		
OCCURRENCE SPAN CODES Field #32-35		
71 Prior stay dates	74 Non-covered level of care	
VALUE CODES Field #39-41		
06 Medicare blood deductible	A1 Deductible payor A	B2 Coinsurance payor B
38 Blood deductible pints	B1 Deductible payor B	X0 Medicare part B payment
39 Pints of blood replaced	A2 Coinsurance payor A	
REVENUE CODE Field #42		
001 Total charges		
REVENUE CODES REQUIRING UNITS OF SERVICE Field #42		
32X Radiology diagnostic	61X Magnetic resonance imaging	81X Organ acquisition
35X CT scan	73X EKG/ECG—electrocardiogram	91X Psychiatric/psychological services—nursing care
42X Physical therapy	74X EEG—electroencephalogram	94X Other therapeutic services
43X Occupational therapy		
PAYOR IDENTIFICATION Field #50		
A Primary payor	C Tertiary payor (always MA)	
B Secondary payor	P Due from patient	
PATIENT'S RELATIONSHIP TO INSURED Field #59		
01 Patient is insuree	06 Foster child	14 Niece/nephew
02 Spouse	07 Ward of court	15 Injured plaintiff
03 Natural child/insured financial responsibility	08 Employee	16 Sponsored dependent
04 Natural child/insured does not have financial responsibility	09 Unknown	17 Minor dependent of a minor dependent
05 Stepchild	10 Handicapped dependent	18 Parent
	13 Grandchild	19 Grandparent
EMPLOYMENT STATUS CODE Field #64		
1 Employed full-time	4 Self employed	6 On active military duty
2 Employed part-time	5 Retired	9 Unknown
3 Not employed		

UB-92 - INPATIENT (Sample)

APPROVED OMB NO. 0938-027

Provider Name Address Telephone Number		2		3 PATIENT CONTROL NO. 09 876543		4 TYPE OF BILL 111	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 03/01/2005 THROUGH 03/09/2005		7 COV D. 8		8 N-C D. 9 C-I D. 10 L-R D. 11	
12 PATIENT NAME Smith, Delia				13 PATIENT ADDRESS 1234 Maple Lane, Phila., PA 19121			
14 BIRTHDATE 01/01/1947		15 SEX		16 MS		17 DATE 03/01/2005	
18 HPT		19 TYPE		20 SRC		21 D HR	
22 STAT		23 MEDICAL RECORD NO. JD12X34YZ		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50 PAYER CBH		51 PROVIDER NO. 01/1234567890002		52 REL INFO		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56		57	
DUE FROM PATIENT							
58 INSURED'S NAME		59 P. REL.		60 CERT. - SSN - HIC - ID NO. 0123456789		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES 7000000		64 MISC.		65 EMPLOYER NAME	
66 EMPLOYER LOCATION		67 PRIN DIAG CD 295.02		68 CODE		69 CODE	
70 CODE		71 CODE		72 CODE		73 CODE	
74 CODE		75 CODE		76 ADM DIAG CD 295.02		77 E-CODE	
78		79 P.C.		80 PRINCIPAL PROCEDURE DATE		81 OTHER PROCEDURE DATE	
82 ATTENDING PHYS. ID MD333333X		83 OTHER PHYS. ID		84 OTHER PHYS. ID		85 PROVIDER REPRESENTATIVE <i>Warry Jones</i>	
86 DATE 03/31/2005		87 REMARKS 123456		88		89	

UB-92 -INPATIENT THIRD PARTY LIABILITY (TPL) (Sample)

APPROVED OMB NO. 0938-027

Feel Good Hospital 651 Jenkins Road Philadelphia, PA 19178 Phone: (215) 999-1010				2		3 PATIENT CONTROL NO. 1571579				4 TYPE OF BILL 111																			
5 FED. TAX NO. 123456789		8 STATEMENT COVERS PERIOD FROM 05/22/2005		THROUGH 05/30/2005		7 COV. ID. 8		8 N-C.D.		9 C-I.D.																			
12 PATIENT NAME Brown, David						13 PATIENT ADDRESS 1234 Oak Lane, Phila., PA 19121																							
14 BIRTHDATE 02/05/1959		15 SEX M	16 MS	17 DATE OF ADMISSION 5/22/2005		18 NP	19 TYPE	20 SRC	21 D HR 19		22 STAT 01	23 MEDICAL RECORD NO. 22771		24		25		26		27		28		29		30		31	
32 OCCURRENCE DATE CODE		33 OCCURRENCE DATE CODE		34 OCCURRENCE DATE CODE		35 OCCURRENCE DATE CODE		36 OCCURRENCE DATE CODE		37 OCCURRENCE SPAN FROM THROUGH A B C		38 VALUE CODES AMOUNT a A1 764 00 b c d		39 VALUE CODES AMOUNT CODE		40 VALUE CODES AMOUNT CODE		41 VALUE CODES AMOUNT CODE		42 VALUE CODES AMOUNT CODE									
42 REV. CD. 001 124		43 DESCRIPTION Total Charges Room and Board				44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS 8		47 TOTAL CHARGES 7202 00 7040 00		48 NON-COVERED CHARGES		49													
50 PAYER Medicare CBH/MAPA				51 PROVIDER NO. 123456 01/01234567890004				52 REL. INFO Y Y Y Y		53 ASG. DEN.		54 PRIOR PAYMENTS 1,996 00		55 EST. AMOUNT DUE 764 00		56													
57 DUE FROM PATIENT												58																	
58 INSURED'S NAME Brown, David				59 P. REL. 01		60 CERT. - SSN - HIC - ID NO. 123456789A 99999999999				61 GROUP NAME		62 INSURANCE GROUP NO.																	
63 TREATMENT AUTHORIZATION CODES 505425				64 EMPLOYER NAME				65 EMPLOYER LOCATION																					
67 PRIN. DIAG. CD. 296.00		68 CODE 30480		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD. 296.00		77 E-CODE		78							
79 P.C. 9		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 OTHER PROCEDURE CODE DATE		83 OTHER PROCEDURE CODE DATE		84 ATTENDING PHYS. ID MD123456E Dr. Mercy				85 OTHER PHYS. ID															
86 REMARKS 123456										87 OTHER PHYS. ID																			
88 PROVIDER REPRESENTATIVE X Mary Jones										89 DATE 07/14/2005																			

EXPLANATION OF BENEFITS (EOB) FOR INPATIENT UB-92 THIRD PARTY LIABILITY (TPL) (Sample)

VERITUS MEDICARE SERVICES FEEL GOOD HOSPITAL		FIFTH AVENUE PLACE, PITTSBURGH, PA 15222 TEL#412-255-7000										PAGE 1											
PART A		PAID DATE: 6/18/05 REMITN: 147																					
Patient Name HIC Number	Patient Cntrl Number ICN Number	RC	RC	DRG# OUTCO	DRG# CAPCD	DRG OUT AMT DRG CAP AMT	COINSURANCE COVID CHGS	PAT REFUND ESRD NET ADJ	CONTRACT ADJ PER DIEM RTE	FROM DT CLM STATUS	THRU DT	NACHG COST	HICHG COVDY	TOB NCOVDY	RC	RC	REM REM	REM REM	PROF COMP DRG OPR AMT	MSP PAYMT DEDUCTIBLES	NCOVD CHGS DENIED CHGS	INTEREST	HCPCS AMOUNT NET REIMB
Brown, David 123456789A 05/22/2005 05/30/2005	1575179 19815609540204	A2 B3	01	HAO2		.00 .00	.00 7202.00	.00 .00	4442.05 345.00														
	QC 8	N	8	111	1	.00 764.00	.00 .00																
Subtotal Fiscal Year 2005																							
Subtotal Part A																							

Co-insurance

Covered charges

Deductible

Covered days

Service from/thru

Net reimbursement

OMHSAS DESK REFERENCE - PROVIDER TYPES

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Inpatient Facility	010	Acute Care Hospital
		011	Private Psychiatric Hospital
		013	RTF (Accredited) Hospital
		018	Extended Acute Psychiatric Inpatient Unit
		019	D&A Rehabilitation Hospital/Unit
		022	Private Psychiatric Unit
		027	RTF (Accredited) Unit
		183	Hospital-Based Medical Clinic
07	Capitation	072	Managed Care Organization - Behavioral Health
08	Clinic	080	Federally Qualified Health Center
		081	Rural Health Clinic
		082	Independent Medical/Surgical Clinic
		084	Methadone Maintenance
		110	Psychiatric Outpatient
		184	D&A Outpatient
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
		09	CRNP
548	Therapeutic Staff Support		
549	Mobile Therapy		
559	Behavioral Specialist Consultant		
11	Mental Health/Substance Abuse	110	Psychiatric Outpatient
		111	Community Mental Health
		112	Outpatient Practitioner - Mental Health
		113	Partial Psychiatric Hospital - Children
		114	Partial Psychiatric Hospital - Adult
		115	Family Based Mental Health
		116	Licensed Clinical Social Worker
		117	Licensed Social Worker
		118	Mental Health Crisis Intervention
		119	Mental Health - OMHSAS
		123	Psychiatric Rehabilitation
		127	D&A Outpatient
		128	D&A Intensive Outpatient
		129	D&A Partial Hospitalization
		131	D&A Medically Monitored Halfway House
		132	D&A Medically Monitored Detox
		133	D&A Medically Monitored Residential, Short Term
		134	D&A Medically Monitored Residential, Long Term
		184	Outpatient D&A
		548	Therapeutic Staff Support
549	Mobile Therapy		
559	Behavioral Specialist Consultant		

OMHSAS DESK REFERENCE - PROVIDER TYPES

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
16	Nurse	162	Psychiatric Nurse
17	Therapist	174	Art Therapist
		175	Music Therapist
19	Psychologist	190	General Psychologist
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
21	Case Manager	138	D&A Targeted Case Management
		212	MA Case Management
		221	Mental Health TCM - Resource Coordination
		222	Mental Health TCM - Intensive
28	Laboratory	280	Independent Laboratory
31	Physician	339	Psychiatry & Neurology
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
34	Program Exception	340	Program Exception
52	Community Residential Rehabilitation	520	Child Residential Service - 3800 (Group Home)
		523	Community Residential Rehabilitaton - Mental Health (Host Home)
56	Residential Treatment Facility	560	Residential Treatment Facility (Non-Accredited)

OMHSAS DESK REFERENCE - MODIFIERS

Modifiers	Modifier Descriptions	Modifiers	Modifier Descriptions
AH	Clinical Psychologist	TF	Intermediate Level of Care
EP	Services Provided as Part of Medicaid EPSDT Program	TG	Complex/High-Tech Level of Care
HA	Child/Adolescent Program	TJ	Program Group, Child and/or Adolescent
HB	Adult Program, Non-Geriatric	TS	Follow-up Service
HE	Mental Health Program	TT	Individualized Service Provided to More than One Patient in Same Setting
HF	Substance Abuse Program	UA	Licensed Children's Program
HG	Opiod Addiction Treatment Program	UB	Behavioral Health Pricing Modifier
HK	Specialized Mental Health Programs for High-Risk Populations	UC	Pilot Program
HO	Masters Degree Level	UK	Someone Other than the Client (Collateral)
HP	Doctoral Level	U1	Psychiatric
HQ	Group Setting	U2	Medicare/TPL Contractual Disallowance
HT	Multi-Disciplinary Team	U7	Pricing Modifier
HW	Funded by State Mental Health Agency	U8	Pricing Modifier
SC	Medically Necessary Service or Supply		

OMHSAS DESK REFERENCE - HIPAA PLACE OF SERVICE CODES

Use only the HIPAA Place of Service (POS) Codes listed below when submitting claims to DBH/CBH. These are the codes expected by DPW for DBH/CBH services. Do not use any other codes listed in the 837 Professional Billing Guide from the Commonwealth of Pennsylvania.

POS	Place of Service Description	POS	Place of Service Description
11	Office	50	Federally Qualified Health Center
12	Home	52	Psychiatric Facility Partial Hospital
15	Mobile Unit	54	ICF/MR
21	Inpatient Hospital	56	Psychiatric Residential Treatment Facility
22	Outpatient Hospital	57	Non-Residential Substance Abuse Treatment Facility
23	Emergency Room - Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other POS
34	Hospice		
49	Independent Clinic		

CMS 1500 - OUTPATIENT (Sample)

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Brown, Lilly					3. PATIENT'S BIRTH DATE MM DD YY 03 28 53 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) 625 Daisy Street CITY: Philadelphia STATE: PA ZIP CODE: 19122 TELEPHONE (Include Area Code): (215) 222-0000					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNED: Signature on file DATE: 06 / 17 / 05					11. INSURED'S POLICY GROUP OR FECA NUMBER 0987654321 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: Signature on file				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 05 24 2005					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 05 26 2005				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE John, Pity, MD					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 11/0012345670501				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 304.0					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 123456				
25. FEDERAL TAX I.D. NUMBER 23-0987654					26. PATIENT'S ACCOUNT NO. 1234				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: Mary Jones DATE: 06/17/2005					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) DNA Center Philadelphia, PA 19111					28. TOTAL CHARGE \$ 160 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					23. PRIOR AUTHORIZATION NUMBER 123456				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
 FORM OWCP-1500 FORM RRB-1500

EXPLANATION OF BENEFITS (EOB) FOR CMS 1500 OUTPATIENT THIRD PARTY LIABILITY (TPL) (Sample)

XACT Medicare Services

EXPLANATION OF MEDICARE BENEFITS



Patient Name Health Insurance Claim Number/Control No.	Proced. Code	No. Svcs.	2		3	4	5	6	7	8	9	10	11	12		
			When From Mo./Day	To Mo./Day											Service Codes PLC/TYP	Yr.
B. Lee	99231	1	12/27	12/27	7	51/1	70.00	35.17		7.03	35.17	0.00	0.00	0.00	28.14	
*CLAIM TOTALS																
Total	Number of Claims	Amount Billed	Amount Apprv'd	Amount Applied to Deductible	Amount Pays 80% of this Amt.	Co-ins	Amount of 80% Payment	Withheld Medicare for Offset	Svcs. Pd. in Full	Medicare Paid Patient	Medicare Paid Provider					
1	70.00	35.17	0.00	35.17	7.03	35.17	0.00	0.00	0.00	0.00	28.14					
SUMMARY			Provider Number: 111111	Week Ending: 1/24/05	Check Number: 034432427	Date Paid: 1/24/05	Page: 1									

XXY Mental Health
1234 N. 100th Street
Philadelphia, PA 19121



Quality Management Program

The Quality Management Program at CBH operates in coordination with the other arms of the Department of Behavioral Health (DBH). DBH/CBH defines, evaluates and reviews all aspects of the delivery of behavioral health services to each individual covered under HealthChoices for Philadelphia County. The goal of DBH/CBH is to insure that appropriate treatment options are provided to clients in a culturally sensitive, quality-driven and supportive environment.

The Quality Review unit functions within the Provider Operations Department so that all aspects of the contracted agency operations are linked to a continuous quality improvement process. The Quality Review unit provides educational outreach to participating providers, and works to assure that participating providers, specialized practitioners and clients are informed about all quality of care and quality of service standards. DBH/CBH requires that providers develop internal quality improvement processes that enhance and support the quality of care delivered. The Quality Review unit works closely with other DBH/CBH departments to monitor the service delivery of providers.

In addition, it is the responsibility of the Quality Review unit to:

- ▶ establish objective and measurable criteria to assess client care
- ▶ establish a system which identifies potential risk and adverse outcome to clients or providers and identify opportunities for improvement
- ▶ participate in provider monitoring and auditing activities to determine compliance with established quality of care and quality of service standards
- ▶ identify and define problems in the delivery of quality care revealed through data collection and analysis
- ▶ assess occurrences with adverse outcomes through the peer review process
- ▶ serve as an advocate for the early detection and treatment of mental illness and substance abuse
- ▶ annually review through the re-credentialing process, the provider's quality improvement efforts to determine the program's effectiveness in achieving the attainment of stated goals regarding the clinical care received by DBH/CBH clients

Provider's Role in the Quality Management Process

DBH/CBH recognizes the importance of collaborating with providers to improve the quality of behavioral health services. The process of delegation of certain quality improvement activities, such as the development and implementation of on-site policies and procedures, is designed to empower the provider to identify necessary improvements to the delivery of care to clients receiving services. Through the work of the Clinical Systems Analysts, DBH/CBH will serve as an advising body to assist providers during the initial development of their own individualized quality assurance program. Once the provider is credentialed, DBH/CBH also serves as a liaison among providers, clients and governing agencies to assess and monitor the progress and ongoing effectiveness of their program.

As part of DBH/CBH's Quality Management Plan, providers are expected to actively participate in activities including, but not limited to:

- ▶ cooperating with focus group studies, work with the Consumer Satisfaction Team and Member Services to resolve quality-of-care issues
- ▶ providing client data for statewide External Quality Review process on a yearly basis
- ▶ responding to client satisfaction surveys
- ▶ reporting significant incidents
- ▶ participating in the resolution of client complaints and grievances
- ▶ submitting aggregate data or documents
- ▶ helping maintain open lines of communication to ensure timely resolution of identified concerns

Further, providers are expected to provide DBH/CBH with copies of records, policies, procedures, state licensing reviews, accreditation surveys, other audits and all documentation as is necessary for DBH/CBH to investigate specific quality concerns. The provider is responsible for the cost of copies, postage, courier or fax services and is expected to provide them to DBH/CBH in a timely fashion.

Clinical Records—Access and Retention

Providers will retain and maintain records for clients in a current, detailed, organized and comprehensive manner in accordance with applicable state regulations and customary professional practice that permits effective quality review.

All records relevant to DBH/CBH clients will be retained by the provider for five years after the final payment is made. All records will be available to DBH/CBH for audit purposes as may be necessary for quality management, compliance and clinical review.

Providers will be responsible for obtaining authorization to release clinical records from each client to DBH/CBH before delivering services. DBH/CBH has the right to inspect medical records, books, billing and financial information maintained by the provider pertaining to the City of Philadelphia, DBH/CBH-covered services and DBH/CBH clients. Costs of copying or transmitting information will be the provider's responsibility.

Documentation and Reporting of Significant Incidents

Philadelphia's Department of Behavioral Health (DBH) has instituted a centralized process for reporting all Significant Incidents. CBH serves as a clearinghouse for this process.

The policy applies whenever a provider reports a significant incident involving adult and child DBH clients of mental health and drug and alcohol services—whether they are:

- ▶ CBH clients receiving in-plan services, or
- ▶ county-funded individuals receiving supplemental funding through the OMH/MR, or CODAAP, including those served by the Behavioral Health Special Initiative (BHSI).

DEFINITION

Significant Incident: Care or treatment that is not routine, and/or is inconsistent with standards of practice, and/or has resulted in injury or potential harm to a DBH/CBH client.

REPORTABLE INCIDENTS

- ▶ death
- ▶ homicide committed by a client who is in service or has been discharged within 30 days
- ▶ suicide attempt requiring medical intervention or hospitalization
- ▶ act of violence, with injury requiring emergency treatment, by or to a consumer/client (MH only if by a consumer)
- ▶ alleged or suspected abuse (physical, sexual, financial) of or by a consumer/client (MH only)
- ▶ adverse reaction to medication administered by a provider that requires medical attention (MH only)
- ▶ neglect which results in serious injury or hospital treatment (MH only)
- ▶ missing person: child who has not returned to home or facility within 8 hours, or at-risk adult who has not returned home within 24 hours
- ▶ arrest (excludes involuntary commitments – 302s)
- ▶ fire or serious property damage at a site where behavioral health services are delivered
- ▶ infectious disease outbreak at a provider site
- ▶ all non-routine discharges from inpatient, residential rehabilitation (D&A), children's residential, detoxification, or methadone maintenance settings, i.e., administrative/involuntary discharges or leaving a facility against medical or facility advice (AMA, AFA)

REPORTING PROCESS

- 1 A copy of all reportable incidents must be faxed to Quality Review at (215) 413-7132 on the attached **Significant Incident Report** form **within 24 hours** of occurrence. This action usually **precedes** an investigation.
- 2 When an internal investigation is warranted, a copy of the investigative report should be **received within 30 days** of the incident. Investigative Reports may be faxed to Quality Review at (215) 413-7132 or mailed to: Quality Review, Community Behavioral Health, 801 Market Street, 7th Floor, Philadelphia, PA 19107.
- 3 Incidents involving physical abuse, sexual abuse, and/or neglect of children must be reported to the State. Providers are mandated by the State to report incidents directly by calling the Commonwealth's CHILDline at (800) 932-0313.
- 4 A missing person who is at-risk should be reported to the Mental Health Delegates by faxing a Missing Person Report Form to (215) 732-2508. The form will be forwarded to all the Crisis Response Centers, so that they can inform you if the missing person presents at one of the crisis centers. The Mental Health Delegates' phone number is (215) 685-6440.

WHERE TO SEND SIGNIFICANT INCIDENT REPORTS:

All reportable incidents must be faxed to Quality Review:

Fax: (215) 413-7132

Investigative reports may be faxed or mailed to Quality Review:

Fax: (215) 413-7132

Mail: Quality Review
Community Behavioral Health
801 Market Street, 7th Floor
Philadelphia, PA 19107

Incidents involving children must be reported to the Commonwealth's CHILDline:

CHILDline phone number: (800) 932-0313

Report an at-risk missing person to the Mental Health Delegates:

Fax Missing Person Report Form to: (215) 732-2508

Mental Health Delegates phone number: (215) 685-6440

OBTAINING ASSISTANCE

If you have any questions about reporting incidents, please contact:

Quality Review: (215) 413-7660

Confidentiality and Release of Information

Confidentiality Policy: Providers will protect the confidentiality of all information in its records from unauthorized disclosure at all stages of collection, use, storage, release of information and destruction. Each provider has the responsibility for safe-guarding the confidentiality of client information. This responsibility is crucial because persons seeking and receiving services offered through DBH providers are entitled to do so with respect and confidentiality by DBH and its contract providers.

This policy applies to all client information and to all client records within the DBH network. A record includes all written clinical information, observations, reports or fiscal documents relating to a prospective, present or past client, when the creation or retention of those documents is either required or authorized as part of operations. It includes central records, individual client records and reports that may be created. This policy does not apply to documents that were public before the provider received them, even if the documents now happen to be in the client's file.

(55 PA Code § 5100.32(h))

A full review of regulations governing this policy explicitly covers all information contained in provider records, including but not limited to the following:

- ▶ information identifying the client, their homes or workplaces or any other personal information
- ▶ medical treatment information
- ▶ mental health treatment information
- ▶ substance abuse treatment information
- ▶ information regarding contraceptives or abortion services that clients have received, including minors who have received such services without parental knowledge or consent
- ▶ information received from county children and youth agencies
- ▶ sexually transmitted disease test results or treatment information
- ▶ HIV test information

Providers receiving a request for information, or needing to release such information for any purposes, may consult this policy. The specific rules that apply to each piece of information are spelled out in detail in the DBH/CBH Delegated Credentialing Manual.



Network Development

Ensuring that treatment providers meet rigorous standards is the primary responsibility of the Network Development Department. DBH/CBH staff are charged with credentialing and recredentialing all providers in the DBH/CBH network, reviewing the qualifications of professional and paraprofessional staff employed by treatment providers in the network, and examining provider policies and procedures that are an integral part of the assurance of the delivery of quality care.

The department also conducts on-site clinical audits, either as a part of a credentialing visit or as a result of concerns about quality-of-care issues raised about a provider. Additionally, the department includes Clinical Systems Analysts who provide technical assistance, education and consultation services to providers in the network. Typically, they assist agency staff in rectifying problems and addressing issues relevant to the provision of quality care, such as poorly written treatment plans, inadequate discharge summaries and developing quality assurance programs.

Network Development facilitates interactions within DBH/CBH and among providers regarding quality-of-care issues and serves as a resource to identify needed specialty services when required by a client. Network Development staff also search for service gaps in the provider system and engage in program development to meet service needs.

The Credentialing Process

The following information is intended to give providers a summary of DBH/CBH's delegated credentialing requirements. All providers should refer to the complete copy of the **DBH/CBH Delegated Credentialing Manual** for more detailed information. It can be found on the DBH/CBH website listed under the Provider section.

DELEGATED CREDENTIALING INTENT

The DBH/CBH approach of delegated credentialing offers providers the opportunity to establish and maintain their own credentialing process, and set their own standards of excellence, while meeting the standards established by DBH/CBH.

Providers are responsible for demonstrating compliance with standards described within the DBH/CBH Credentialing Manual. The process of delegated credentialing holds each provider responsible for:

- ▶ establishing a method of credentialing all direct care, supervisory and professional staff
- ▶ developing and maintaining standards of clinical practice, both discipline and provider specific
- ▶ identifying methods of assessing quality of care through written standards
- ▶ determining outcome standards that measure aspects of care based on the results of treatment, which includes client satisfaction

The process of delegated credentialing allows DBH/CBH credentialing analysts to evaluate each provider's compliance with their own standards, laws and guidelines, which are established by federal, state and discipline-specific licensing and/or oversight bodies. Each provider is expected to demonstrate their own processes for credentialing staff and ensuring quality of care, which follow DBH/CBH guidelines and standards.

Evaluation for compliance is accomplished through:

- ▶ assessment of the provider's policies and procedures which relate to credentialing of staff
- ▶ evaluation of the provider's methods of quality assurance, including internal audits and continuous quality improvement plans
- ▶ review of direct care and supervisory files to ascertain compliance with established standards necessary for each position
- ▶ review of job descriptions for each position

DBH/CBH reserves the right to conduct on-site review of the physical plant to ensure issues of safety within the facility.

RE-CREDENTIALING

Statement of Intent: Every provider within the DBH/CBH network must undergo a provider review process at least every 2 years. This could include a full credentialing or re-credentialing, and a targeted or quality review. More frequent visits may be scheduled by DBH/CBH at any point if one or both of the following apply:

- ▶ The provider has been granted a credentialing status which dictates a site visit within a specific time frame.
- ▶ There are reasons for concern about quality of care.

Recredentialing Readiness: Each provider is responsible for maintaining the following documentation for re-credentialing purposes for the facility or entity:

- ▶ updated **Provider Application** (if necessary) or a **Provider Verification** form
- ▶ current license and certification(s)
- ▶ complete clinical files and supervisory staff files available for review
- ▶ proof of current professional and general liability insurance
- ▶ proof of a current **PROMISe Number** (Pennsylvania Medical Assistance provider number)

The specific required documents for a review can be found in the Credentialing Manual available on the DBH/CBH website at www.phila-bhs.org or by contacting the Credentialing Manager at (215) 413-3100.

The provider shall also furnish quality improvement documentation, including:

- ▶ peer review process and outcomeS data
- ▶ clinical monitoring and evaluation results
- ▶ clinical quality monitoring forms
- ▶ client satisfaction surveys
- ▶ grievances and complaints
- ▶ incident reports

Providers will be notified in writing of the results of the credentialing visit by the CBH Board of Directors. Providers will be given specific details about the outcome of the audit, including all scores and a written summary. The decision of the CBH Board of Directors is considered final.

Clinical Chart Audits

The clinical chart audit process occurs during a credentialing visit. It may also result from concerns about quality-of-care issues involving a provider. A clinical audit is considered an integral component of the re-credentialing process. All providers must anticipate and prepare for review of open and closed charts during a re-credentialing visit. Prior to a site visit, DBH/CBH will notify the provider of the intent to review and conduct a clinical chart audit. Client charts are reviewed by the credentialing analysts, all of whom are trained to perform both clinical and administrative reviews.

It is expected that providers in the DBH/CBH network consistently adhere to DBH/CBH standards regarding quality-of-care and clinical record keeping requirements.

Technical Assistance

The DBH/CBH provider network is continually reviewed to determine if it continues to meet the behavioral health needs of DBH/CBH clients. To this end, information obtained from multiple objective sources include (but are not limited to): clinical chart audits, quality-of-care reviews, credentialing scores, significant incidents, client satisfaction and general business operations. These are used to measure the effectiveness of the service delivery of provider agencies. DBH/CBH is committed to building partnerships with providers in order to develop programs that better serve DBH/CBH clients. Clinical Systems Analysts are responsible for providing technical assistance, education and consultation to providers. Providers may request or be recommended for Technical Assistance by the CBH Board of Directors. Clinical Systems Analysts respond to systemic problems in an agency and serve as short-term consultants to providers; to rectify problems and issues relevant to the provision of quality care (i.e., poorly written treatment plans and inadequate discharge summaries) and the development of internal quality assurance programs.

The Network Development Department continues to adapt to meet changing needs, as it works to assist providers in developing and maintaining policies, procedures and staffing patterns that assure the provision of quality care.

Program Development

The Network Development staff is continually engaged in the process of maintaining the network of providers to assure that there are sufficient resources to meet the needs of our clients. The ongoing assessment of the provider network includes those providers who contract for services with the other arms of DBH. While there are some contracting and funding differences, essentially all providers delivering behavioral healthcare services to Philadelphia citizens should view themselves as part of the DBH system. To this end, CBH will coordinate with the OMH/MR, CODAAP and BHSI to monitor, develop and support programs that provide needed services that focus on the fundamentals of care and rely on evidenced-based practices.

COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT

DBH/CBH will operate in compliance with the Federal Americans with Disabilities Act of 1990 (ADA). Specifically, no individual will be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination by DBH/CBH or its contracted provider network.

Programs and services within the provider network are accessible to individuals with disabilities. Compliance with ADA is achieved if services and programs are located in accessible facilities, or if another arrangement is in place to bring the program or service to the individual. Some examples include relocating a program to an accessible facility, allowing home visits instead of office visits, arranging to meet an individual at an accessible location and any other modifications in procedures or policies that would enable qualified people with disabilities to participate.

The provider network is required to remove “non-physical” barriers to service and will make available at the request of its clients the following:

- ▶ telecommunications devices for the deaf
- ▶ assisted listening devices
- ▶ large-print/Braille forms
- ▶ sign language services
- ▶ Computer Assisted Real-Time Transcription (CART)

CBH Member Services and Network Development work in cooperation to insure that members and providers meet this goal.

Utilization and Supervision of Graduate Students in Field Placements

All DBH agencies that have graduate students who deliver outpatient client care in field placements, practicum or internships are reimbursed at regular DBH/CBH non-psychiatric rates. However, only students who have completed at least one year in a behavioral health-related graduate program qualify for reimbursement. Supervision requirements are more stringent to insure that the interns provide quality care and fully inform clients of their training status.



DBH/CBH Compliance Policies

Under the HealthChoices Behavioral Health Program, DBH/CBH receives state and federal Medicaid funding for payment of services for eligible Medicaid clients. DBH/CBH has the responsibility to insure that Medicaid funding is spent according to federal and state rules. Both DBH/CBH and the providers have the responsibility to have systems in place to prevent fraud and abuse of these funds.

Definitions

FRAUD, as defined by the Center for Medicare and Medicaid Programs (CMS), “Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting.”

ABUSE, as defined by CMS, “Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the MA program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Provider Agreement, and the requirements of the state or federal regulations) for health care in a managed care setting.”

Statute Title 42, Section 1320 Medicare/Medicaid Fraud is specifically designed to control and prevent fraud in connection with claims under the Medicare or Medicaid programs. Providers found to be non-compliant could face hefty fines (e.g. up to \$10,000 for each claim plus treble damages), temporary and permanent exclusions from the Medicare and Medicaid programs, and criminal prosecution and imprisonment. Penalties will apply not only to those who knowingly engage in improper practices but also to those who deliberately ignore or recklessly disregard their legal obligations.

Examples of Specifically Prohibited Activities

- ▶ billings for services not rendered
- ▶ misrepresenting the services rendered
- ▶ falsely certifying that services met medical necessary criteria
- ▶ submitting a claim for physician services by an unlicensed individual
- ▶ making false statements or representations related to an institution’s compliance with its Conditions of Participation
- ▶ retaining Medicare or Medicaid funds that were improperly paid
- ▶ billing multiple funding streams for the same services

Provider's Responsibility

PROVIDER COMPLIANCE PLAN

Providers are required to have a corporate compliance program that is designed to minimize an organization's risk of violating federal and state statutes and regulations related to the Medicare and Medicaid programs. The Office of the Inspector General (OIG) of the United States has published guidance for various types of healthcare providers in developing compliance programs. In addition the U.S. Sentencing Commission has published the areas which should be included in a comprehensive corporate compliance program. The seven areas are as follows:

- 1 written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards
- 2 designation of a compliance officer and compliance committee accountable to senior management
- 3 effective training and education for compliance officer and organization's employees
- 4 effective lines of communication between compliance officer and organization's employees
- 5 enforcement of standards through well publicized disciplinary guidelines
- 6 provision for internal monitoring and auditing
- 7 provisions for prompt response to detected offenses and the development of corrective action initiatives

PROVIDERS, AS PARTICIPANTS IN THE MEDICAL ASSISTANCE (MA) PROGRAM, MUST:

- ▶ Follow all state MA regulations and ensure that all services for which they have received payment follow all of the appropriate rules.
- ▶ Have a system to ensure that employees know, understand, and comply with the legal requirements that apply to the business. These include rules and regulations for clinical documentation, physical plant requirements and those related to claims submission.
- ▶ Be able to prove that they have provided all the services for which they have submitted a claim.
- ▶ Have documentation to support that the services billed were covered by DBH/CBH.
- ▶ Have mechanisms to identify, investigate and take corrective action for suspected or substantiated fraud and abuse activities.
- ▶ Notify the DBH/CBH Compliance Department of suspected program or client fraud and abuse within 24 hours of discovery.
- ▶ Participate in announced and unannounced Compliance audits.
- ▶ Display the DBH/CBH Compliance Hotline posting in all clinical areas.

Monitoring of Fraud and Abuse by DBH/CBH

The Compliance Department of DBH/CBH has been charged with the responsibility to:

- ▶ monitor compliance with Medicaid regulations
- ▶ perform routine and special audits of providers
- ▶ report activities to the Compliance Committee, the CBH Board of Directors and the other components of DBH
- ▶ provide education and training for employees and providers
- ▶ develop and monitor corrective actions taken by providers as a result of audit activities
- ▶ maintain a fraud and abuse hotline
- ▶ maintain a cooperative relationship with governmental oversight agencies and fully cooperate in any investigation of suspected fraud and abuse

In addition, special features have been and continue to be incorporated into the Claims Payment System at CBH to automatically scan and prevent payment of services that may potentially constitute fraud or abuse. These features or “edits,” as they are called, include, but are not limited to, the prevention of payments for services that have:

- ▶ not been authorized
- ▶ been previously paid
- ▶ been provided to persons who were ineligible for treatment

Reports have been and continue to be developed in the Claims Payment System to monitor provider activity relating to services billed, including both payment and rejections, for purposes of identifying potential fraud and abuse.

DPW’s Medichex List is also reviewed on a monthly basis to determine if any DBH/CBH providers are on the list.



Glossary of Terms

Abuse: Payment for those items or services, where no legal entitlement exists and for which the health care provider has not knowingly or intentionally misrepresented the facts to receive payment.

Acute Partial Hospitalization: Acute partial hospitalization is a hospital-based program designed for the treatment of clients with acute psychiatric illness, or clients who are chronically ill and marginally functional and who require a more intensive and supervised treatment program than that which is afforded by various types of outpatient or aftercare programs. It provides an array of intensive psychiatric, medical, behavioral and developmental services to address the needs of individuals with acute psychiatric symptoms and reduced functionality who do not require hospitalization.

Addendum: Additions or changes to an already completed, full and comprehensive evaluation, based on either the exchange of clinical information or a face-to-face meeting with the client.

Adjudication: The process of reviewing and editing claims to determine whether services were performed in accordance with government regulations, insurance company policies and contractual agreements with the provider.

Affiliated Provider: A health care provider or facility that is part of the Managed Care Organization's network, usually having formal arrangements to provide services to the MCO's member.

Assessment: The preliminary compilation of biopsychosocial information, derived by interviewing a client and family members or caretakers, and reviewing past clinical records, to determine level of care placement.

Behavioral Health Care Company: (see Managed Care Organization).

Behavioral Health Care Services: Mental health and substance abuse treatment services.

Behavioral Health Rehabilitation Services (BHRS): The coordination of delivery of services to children and their families that is individually tailored to each case with the goal of keeping the family together in the community and being included in normalized school settings. BHRS was formerly called EPSDT.

Care Management: The managed care organizational function with the responsibility to authorize and coordinate the provision of in-plan services.

Case Management: The process by which all health-related matters of a case are managed by a designated health professional, who assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation, and recreation. Case management is intended to ensure continuity of services and overcome fragmentation within service systems. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Capitation: A dollar amount established to cover the cost of health care services delivered for a person during a specified length of time. The term usually refers to a negotiated per person rate that is paid periodically to a health care provider by a MCO. The provider is then responsible for delivering or arranging for all of the health services required by the enrolled person under the provider's contract.

Carve-Outs: A payer strategy in which a payer separates ("carves-out") a portion of the benefit and hires an MCO to provide these benefits. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service "carved out."

CBH Provider Number: The CBH provider number is the number assigned to each provider by the CBH IS system. A provider will have an assigned CBH provider number for each provider type and location it contracts with CBH to provide. CBH provider numbers are used in the authorization process.

Centers for Medicare & Medicaid Services (CMS): The agency within the Department of Health and Human Services which administers federal health financing and related regulatory programs, principally the Medicare, Medicaid, and Peer Review Organization.

Clean Claim: A claim that can be processed without requiring additional information from the provider or the Third-Party Payor.

Clean Rejected Claim: A claim that is returned to the provider or Third-Party Payor due to ineligible recipient or service.

CMS 1500 Claim Form: The Center for Medicaid and Medicare's standard form for submitting outpatient service claims to insurance companies.

CODAAP: Coordinating Office for Drug and Alcohol Abuse Programs, a component of the Philadelphia's Department of Behavioral Health.

Complaint: An issue, dispute or objection presented by or on behalf of a member regarding a participating health care provider, or the coverage, operations or management policies of a managed care plan.

Community Support Services: Community Support Services are a range of services designed to assist adults and children to function in the community. Services include: Intensive Case Management, Resource Coordination, Family-Based Mental Health Services and Crisis Residences.

Concurrent Review: A review process conducted after admittance to a level of care and prior to the expiration of the current authorized length of stay.

Coordination of Benefits: The process by which the cost for a covered service provided to a member in the event of an incident of sickness may be recovered from a member's primary insurer.

Coordination of Care: The process by which a member's care is coordinated to assist in the diagnosis and treatment of the member's psychiatric condition through consultations and exchange of pertinent information and events between the member's PCP and Behavioral Health Provider.

Co-payment: The portion of health care costs that the covered individual is expected to pay. Providers are specifically prohibited from charging co-payments to Medicaid recipients.

Consumer Satisfaction Team: In Philadelphia, the Consumer Satisfaction Team (CST) is an organization staffed by consumers and family members of consumers of mental health and substance abuse treatment services. The CST conducts visits to service sites year-round to ascertain consumer satisfaction with mental health and substance abuse treatment services in an effort to assure continued satisfaction with these services. Unlike organizations which solicit information through written questionnaires, the CST meets with consumers face to face to ensure that consumers have a voice in the choice and quality of their service. The CST meets regularly with staff from the Department of Behavioral Health to resolve consumer concerns.

Credentialing: A mechanism by which an MCO ensures that the treatment received by members is of high quality and that it is delivered by well-qualified professionals.

Cultural Competence: An awareness and acceptance of cultural differences, an awareness of one's own cultural values, an understanding of the "dynamics of difference" in the helping process, basic knowledge about the client's culture, and the ability to adapt practice skills to fit the client's cultural context.

Crisis Residences (CR): Crisis Residences provide short-term residential options in a community setting to persons in crisis, to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.

Delegated Credentialing: In its Delegated Credentialing process, CBH offers providers established guidelines on which to base their own Credentialing Program. Subsequently, CBH reviews a provider's Credentialing Program and evaluates adherence to their program.

Disenrollment: The process of removing members from eligibility in Medicaid. Disenrollment of members lies within the sole authority of the Pennsylvania Department of Public Welfare.

Drug & Alcohol (D&A) Addictions Professional: A nationally accredited addictions practitioner, or a person possessing a minimum of a bachelor's degree in social science and two years experience in treatment/case management services for persons with substance abuse/addiction disorders.

Dual Diagnosis. A diagnosis of an emotional disorder and another disorder such as drug and alcohol abuse, developmental disability or a mental illness.

Eligibility: Member eligibility for behavioral health services under the HealthChoices Program is determined solely by the PA Department of Public Welfare.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services under the Medical Assistance Program and are needed to evaluate or stabilize an emergency medical condition.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT program covers screening and diagnostic services to determine physical or mental problems in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Evaluation: The comprehensive gathering of biopsychosocial information through client interview, discussion with family members or caretakers, review of clinical records, and contact with collaborating agencies that leads to biopsychosocial formulation, diagnoses, and a biopsychosocial treatment plan.

Explanation of Benefits (EOB): A summary of benefits provided to subscribers or treatment providers by the insurance carrier.

Family-Based Mental Health Services (FBMHS): The Family-Based Mental Health Program provides short-term treatment services to children and adolescents and their families with mental health and/or substance abuse disorders. The program provides a variety of services to families in their home, including traditional therapy services and non-traditional services such as respite services for families, transportation and linkage with other service systems and community resources. The program services children who are at risk for psychiatric hospitalization, or placement out of the home.

Federal Medicaid Managed Care Waiver Program: The process used by states to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries. This refers to the waiver of certain sections of the Social Security Act, Title XIX which requires states that pay for Medicaid on a fee-for-service basis to assure that all recipients of health care services have comparable services made available on a state-wide basis and that persons have freedom of choice of providers. Such waiver is required to provide Medicaid funded services in a prepaid managed care program in a cost effective manner.

Federally Qualified Health Center (FQHC): A center receiving a grant under the Public Service Act or an entity receiving funds through a grantee of the Act. These include community health centers, migrant health centers and health care for the homeless population. FQHC services are mandated Medicaid services, health education, and mental health services.

Fee-For-Service: A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed. This is considered the traditional form of health insurance.

Fraud: Intentional deception or misrepresentation that is made by an individual who knows it to be false and who receives an unauthorized benefit from the action.

Freestanding Facility: Usually refers to an autonomous treatment service that is not connected with a hospital or to other services (e.g., a freestanding detoxification unit).

Grievance: A request from a member, or a provider with the member's written permission, for a reversal of the Behavioral Health Managed Care Provider's decision to deny authorization of an in-plan service prescribed for the member by an appropriately qualified practitioner.

HealthChoices Program: Pennsylvania's 1915(b) waiver program to provide mandatory managed care to Medical Assistance recipients who reside in Bucks, Chester, Delaware, Montgomery and Philadelphia counties. Medicaid recipients must now enroll in a Managed Care Organization which has entered into a contract with the Commonwealth of PA to provide comprehensive physical health services. In Philadelphia County, behavioral health services (mental health and substance abuse) are managed by Community Behavioral Health (CBH), a not-for-profit city-affiliated managed behavioral health care corporation established by the City of Philadelphia.

Health Maintenance Organization (HMO): An HMO is an organization that, for a prepaid fee, offers, provides or arranges comprehensive health care services to enrolled members. The HMO is licensed to provide its services to persons living within one or more counties in the state. HMOs typically offer a range of health care services at a fixed price (see Capitation).

Individualized Education Program (IEP): A federally-mandated written individual plan of services for all children with disabilities who qualify for special education. It is developed jointly by parents and school personnel.

Inpatient treatment: Services provided in an acute hospital or non-ambulatory setting under the care of a physician for no less than 24 hrs.

Inquiry: Any behavioral health member's request for administrative service or information, or to express an opinion. When specific corrective action is requested by the member, or determined to be necessary by the MCO, an inquiry is upgraded to a complaint.

In-Plan Services: Services which are the responsibility, under the HealthChoices program, of the behavioral health care Managed Care Organization.

Intensive Case Management (ICM): ICM is a service for persons with a major mental illness and/or a significant substance abuse problem who experience frequent hospitalizations or times of crisis and may be unable to get or keep a safe place to live, or identify, reach and maintain personal goals. Intensive case managers typically meet with clients once a week, but are also available on a 24-hour, 7-days a week basis. They generally assist clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation and recreation.

Intensive Outpatient Treatment (IOP): Intensive Outpatient Treatment is appropriate for persons with alcohol or drug problems who need assistance in beginning or maintaining recovery, but who do not require detoxification or hospitalization. Outpatient Programs may be offered on various schedules, such as days, evenings, weekends and combinations of these. Programs are of varying durations, and may be used as a transitional step between an initial crisis and/or re-entry into daily living activities, depending on need.

Interagency Team: A multi-system team comprised of the child, where appropriate, the adolescent, a responsible family member, a representative of the mental health program, the case manager, and where applicable, the county children and youth, juvenile probation, mental retardation and drug and alcohol agencies, a representative of the responsible school district, MCO, PCP, and other agencies that are providing services to the child or adolescent.

MA Provider Agreement: Any provider wishing to provide services to eligible Medical Assistance or recipients must have a current agreement with the Pennsylvania Department of Public Welfare.

Maintenance Psychiatric Partial: Maintenance Psychiatric Partial Hospital is a non-hospital based program that provides less than 24 hour care for individuals who are stabilized post-crisis, but require ongoing, non-acute support than that available in traditional outpatient or aftercare programs. These programs provide an array of services which includes medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental services. Unlike the acute partial, the array of services are offered on a longer-term basis and are more related to psychosocial rehabilitation.

Managed Care Organization (MCO): An entity, operated by county government or a private vendor, organized to manage the financing and delivery of mental health and substance abuse treatment services to members under the HealthChoices program. CBH is the MCO to which this manual refers.

Managed Care: A broad term used to describe organizations that combine delivery and payment of health care services to control costs and utilization of services. Many states now use managed care as a way of ensuring quality in a cost-efficient manner within publicly funded programs. It may or may not include a capitation arrangement, by which the HMO is reimbursed with a set fee “per capita” or per person.

Medicaid: A medical benefits program for individuals who meet income criteria and are aged, blind, disabled, or members of families with dependent children. States have flexibility in setting their own eligibility criteria. The program is jointly paid for by the State and Federal governments, but administered by the State. Medicaid is the nation’s largest program providing medical and health-related services to more than 31 million of America’s poorest people. With about 1.3 million adults and children on public assistance, Pennsylvania ranks fifth in the nation in the number of its Medicaid recipients.

Medical Assistance (MA): The Commonwealth of Pennsylvania’s term for Medicaid. (Includes some reimbursable services that are not federally required.)

Medicare: A nationwide, federally financed health insurance program for people age 65 and older. It also covers certain people under 65 who are disabled or have chronic kidney disease. Medicare Part A is the hospital insurance program; Part B covers physicians’ services. Created by the 1965 amendment to the Social Security Act. Medicare is run by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

Member: Any person who is eligible for behavioral health services under the Medical Assistance program who is covered by the HealthChoices program.

Mental Health (MH) Professional: A person trained in a recognized clinical discipline including, but not limited to psychiatry, social work, psychology and nursing who has a graduate degree and mental health clinical experience.

ODAP: Formerly, the Commonwealth of Pennsylvania's Office of Drug and Alcohol Programs (now known as Bureau of Drug and Alcohol Programs —BDAP).

OMH/MR: Philadelphia's County Office of Mental Health and Mental Retardation.

OMHSAS: Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services.

Out-of-Plan Services: Services which are non-plan and are not the responsibility of the MCO under the HealthChoices program but must be coordinated with in-plan service delivery.

Pended Claim: A claim that is put on temporary hold in order to determine what portion of the charges, if any, may be covered by a Third-Party Payor.

Psychological Testing: The employment of professionally recognized, standardized instruments that have been determined to be useful for a variety of diagnostic and treatment planning purposes.

Primary Care Physician (PCP): A primary care provider such as a family practitioner, general internist, pediatrician and sometimes an OB/GYN who serves as the initial interface between the member and the medical care system. Generally, a PCP supervises, coordinates and provides medical care to members of a plan. The PCP is the designated health care case manager contracted by the HMO. All general medical care is provided by the PCP and all specialty referrals must go through the PCP.

Prior Authorization: An authorization from Medicaid or other insurance carriers for the delivery of services. It must be obtained before the service is provided in order for the benefits to be paid. Emergency services do not require prior authorization.

PROMISE Number: Each provider has a PROMISE number assigned by the Pennsylvania Department of Public Welfare signifying participation in the Pennsylvania Medical Assistance Program.

Provider Agreement: The written agreement between the provider and the Managed Care Organization to render clinical or professional services to members to fulfill the requirements of the HealthChoices program.

Provider Networks: Organizations of health care providers that service managed care plans. Network providers are selected with the expectation that they will deliver quality care in a cost effective manner.

Quality Improvement (QI): Process by which the Managed Care Organization continuously measures, assesses and improves the performance of clinical processes and other processes involved in providing care and services in the provider network and internally.

Quality Management: A formal set of activities to assure the quality of services provided. Quality management includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Residential Continuum Treatment Facility (RCTF): A part of a comprehensive treatment program for children and adolescents with severe to moderate behavioral health care needs in a community-based residential setting.

Residential Treatment Facility (RTF): A part of a comprehensive treatment program for children and adolescents with severe to moderate behavioral health care needs in a community-based residential setting.

Resource Coordination (RC): RC is a service for persons with serious mental illness and/or substance abuse problems who may have mild to moderate difficulty in social, job-related or daily living skills. Resource coordinators typically meet with clients anywhere from 2-3 times a month to every other month, depending upon need, but are also available during weekday business hours in the event of difficulty. They generally assist clients to obtain and coordinate community resources, and to provide training, support and assistance in living safely in the community and maintaining stable relationships, housing and employment.

Risk Management: A process intended to identify and minimize potential injury to persons and/or financial loss.

Significant Incident: Care or treatment that is not routine, and or is inconsistent with standards of practice, and/or has resulted in injury or potential harm to a BHS client.

Supplemental Security Income (SSI): A federal cash-assistance program which is based on certain eligibility criteria relating to disability or age and income. Disability under SSI means having a physical or mental impairment that prevents the individual from being gainfully employed and is expected to last for at least a year or result in death.

Third Party Liability (TPL): Refers to the existence of other insurance carriers that have primary responsibility for coverage.

Unclean Rejected Claim: A claim that must be returned to the provider or Third-Party Payor for additional information.

Urgent care: Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) period and, if left untreated, could rapidly become an emergent situation.

UB-92 Claim Form: Bill form used to submit hospital insurance claims for payment by insurance carriers. Similar to CMS 1500 but reserved for the inpatient component of health services.

Utilization: The extent to which members of a covered group use a program or obtain a particular service or category of procedures over a set period of time. This is usually expressed as the number of services used per year per numbers of persons eligible for the services.

Utilization Management (UM): The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. UM integrates review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

Utilization Review (UR): A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis. Utilization Review is a mechanism used to ensure that a member receives the appropriate level of care, that medical necessity is demonstrated, and that the level of care is the least restrictive and least expensive level necessary using established accepted guidelines.



Community Behavioral Health

MEMBER HANDBOOK

Your guide to
Mental Health and
Substance Abuse
Services

CBH is a component of the

Behavioral Health System

serving Philadelphia's uninsured, underinsured
and Medicaid-eligible residents

ATTENTION!

If you do not understand English, please call Member Services at 1-888-545-2600. Someone there who speaks Spanish will help you get services in Spanish. They will also send you this handbook in Spanish.

ВНИМАНИЕ!

Если вы не понимаете по английски звоните 1-888-545-2600. Вам помогут и пошлют эту книгу на русском языке

ATENCIÓN!

Si usted no habla ingles, por favor de llamar al Servicio de Miembrecia al 1-888-545-2600. Alguien que hable Español le ayudará a obtener servicios en Español. Se le mandara este guía en Español.

CHÚ Ý!

Nếu bạn không hiểu tiếng Anh, xin gọi Phục Vụ dành cho Hội Viên số 1-888-545-2600. Nơi đó sẽ có người nói tiếng Việt giúp bạn tìm những phục vụ có tiếng Việt cho bạn. Và họ sẽ gửi đến cho bạn một quyển sách tay tiếng Việt.

ຈົ່ງລະວັງ !

ຖ້າວ່າທ່ານບໍ່ເຂົ້າໃຈພາສາອັງກິດ, ກະລຸນາໂທໄປຫາຫ້ອງການພະນັກງານ: 1-888-545-2600. ມັນຈະມີຄົນປາກພາສາຂອງທ່ານເພື່ອຊ່ວຍຮັບໃຊ້ທ່ານ. ແລ້ວເຂົາຈະສົ່ງໜັງສືຄູ່ມືທີ່ເປັນພາສາລາວມາໃຫ້ທ່ານອີກດ້ວຍ.

សេចក្តីជូនដំណឹង!

បើអ្នកជាសមាជិក មិនចេះឬមិនយល់ភាសាអង់គ្លេស សូមទូរស័ព្ទទៅលេខ 1-888-545-2600 មានអ្នក និយាយភាសាបស់អ្នក នឹងជួយអ្នកហើយ និងផ្ញើរ កូដសៀវភៅអំពីព័ត៌មានជាភាសាខ្មែរមកជូនអ្នក។

請注意!

如果您不會說英文，請打 1-888-545-2600 免費服務電話，有說您語言的服務員協助您得到各項服務。您還會得到這本手冊的中文翻譯本。



Community Behavioral Health

MEMBER HANDBOOK

Your guide to
Mental Health and
Substance Abuse
Services

CBH is a component of the
Behavioral Health System

serving Philadelphia's uninsured, underinsured
and Medicaid-eligible residents



Table of Contents

What is the Behavioral Health System?	1
How Do I Find Out About Services?	2
Member Services	3
Emergencies	4
Transportation	7
What Services Can I Get?	8
Provider List	9
Child and Adolescent Services	10
Interagency Meetings	12
Family's Rights	14
Your Rights	15
Advance Directives	18
Confidentiality	19
Your Responsibilities	20
Getting Services Outside of Philadelphia	21
What If I am Unhappy with My Services?	22
Complaints	23
Grievances	30
Who Can I Call for Help?	44
Ombudsperson	46
Consumer Satisfaction Team, Inc.	47
What Do These Words Mean?	48



What is the Behavioral Health System?

- ▶ The Behavioral Health System connects you to Adult, Child and Adolescent Mental Health and Substance Abuse services.
- ▶ Everyone who is on Medical Assistance (**MA**) in Philadelphia must use the Behavioral Health System to get his or her Mental Health and Substance Abuse services.
- ▶ To be connected to the Mental Health or Substance Abuse services you need, you must go through an agency called Community Behavioral Health (**CBH**).
- ▶ Through CBH, you can find the service you need, get approval for treatment and help with appointments, transportation and emergencies.
- ▶ Although you will receive your Mental Health and Substance Abuse services through CBH, you will still get your physical health services through your HMO.
- ▶ You can also access these services through the Federally Qualified Health Centers, at any of their Philadelphia locations.



How do I find out about services?



Just call:

Member Services

1-888-545-2600

- ▶ If you need help finding Mental Health and Substance Abuse services, you should call Member Services. You can reach them at their toll free number: 1-888-545-2600.
- ▶ If you are hearing impaired, you can call Member Services using the **TTY/TDD** number: 1-888-436-7482.
- ▶ Whenever you call Member Services, you can ask to talk to the same person. This person will be your Member Services Representative. (If your representative is not there, someone else will help you).
- ▶ It is important to call Member Services before going to a service. This way Member Services can help you find a covered service.
- ▶ A covered service is a service that is given the okay by the Behavioral Health System. If you go to a service that is not covered, you might have to pay for it yourself.
- ▶ **This Managed Care Plan may not cover all your health care expenses. Read your *Handbook* carefully to determine which health care services are covered.**



Member Services...

Your link to care!

1-888-545-2600

▶ **When you call Member Services, they may:**

- ask you questions to find out what kind of services you need.
- recommend where you can go to get services that are *pre-approved* (will be paid for).
- help make appointments for you
- refer (send) you to crisis services when you have an emergency.
- answer your questions about the Behavioral Health System.

▶ **Member Services can also:**

- help find out if a service you ask for is covered or paid for by CBH.
 - help you get transportation to your appointments, if necessary.
 - help solve problems you may have with the services you are getting.
 - respond to your complaints and/or grievances.
- ▶ Member Services will answer your call 24 hours a day, 7 days a week.
- ▶ If you do not understand English, Member Services will find someone who speaks your language and try to find you a treatment program where your home language is spoken.



Emergencies

- ▶ **If you are an adult who is having a Mental Health or Substance Abuse emergency, you may go to any of Philadelphia's 5 Crisis Response Centers (CRCs) 24 hours a day, 7 days a week.** These 5 "CRCs" are located in different parts of the city, so there is one fairly close to where you are in Philadelphia. **(See the list of Crisis Response Centers on the next page).**
- ▶ **FOR ALL CHILDREN AND TEENAGERS (under age 18), please go to Albert Einstein @ Germantown Community Center at One Penn Boulevard, (215) 951-8300.**
- ▶ If you are thinking about hurting yourself, please call the **SUICIDE HOTLINE** at **215-686-4420**.
- ▶ Someone will always be able to take your emergency call 24 hours a day, 7 days a week.
- ▶ If you are not sure where to go, call the Delegate Line at (215) 685-6440. The Delegate Line will be able to help you in an emergency. They will direct you to the nearest service that will meet your needs.
- ▶ If necessary, the Delegate Line will send the Mobile Emergency Team (MET) to your location.
- ▶ Because not all emergency rooms serve children, call the **Delegate Line** at **215-685-6440** to get immediate help for children. They will send someone to your home or tell you where to take your child.

If there are any major changes to this process, you will get a letter telling you about them. You will get 30 days notice.

If your emergency is life threatening, go directly to the nearest Emergency Room.



Emergencies - Continued

You can also call 1-888-545-2600 and Member Services will connect you to the crisis hotline.

Crisis Response Centers

Hall Mercer/ PA Hospital
8th & Locust Street
(215) 829-5249

Center City
South Philadelphia

Mercy Hospital
501 S. 54th Street
(215) 748-9525

Southwest/ West
Philadelphia

Temple / Episcopal Hospital
100 E. Lehigh Avenue
(215) 707-2577

North Philadelphia

Einstein Hospital
@ Germantown Community
Health Center
One Penn Boulevard
(215) 951-8300

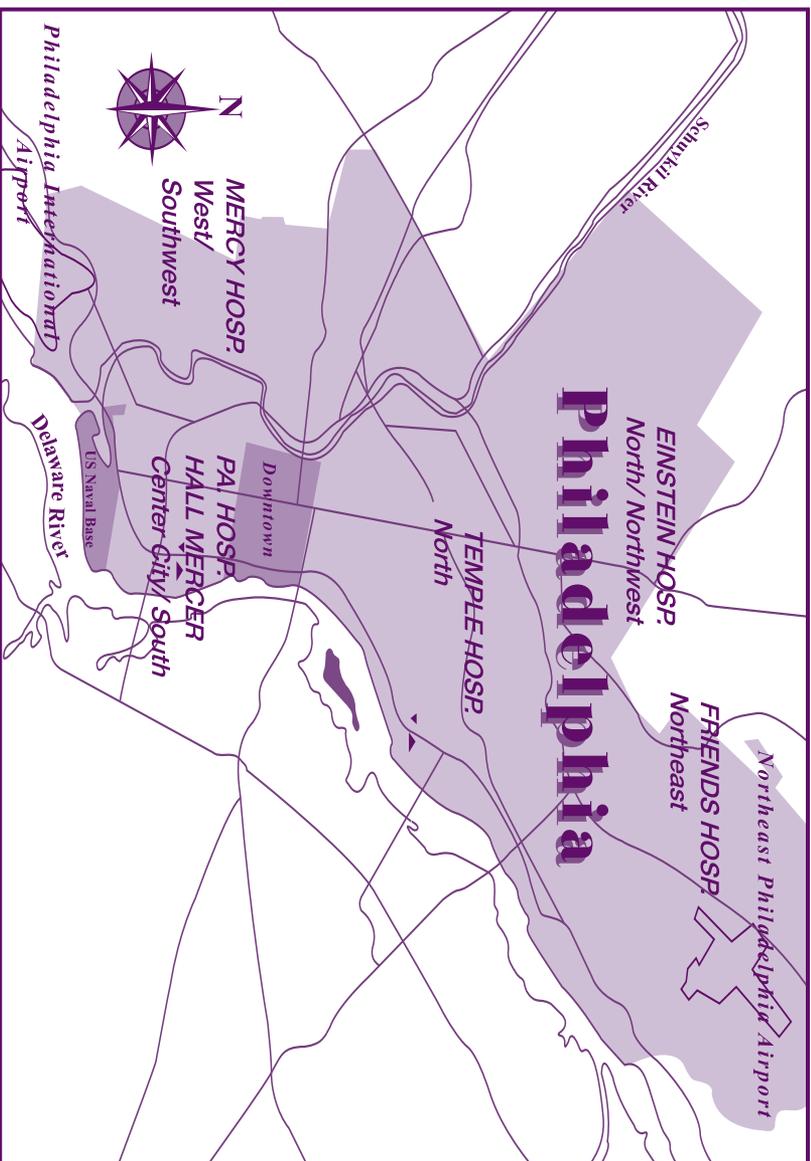
Northwest
Germantown
Roxborough
Assesses Children City Wide

Friends Hospital (Larkspur)
4641 Roosevelt Boulevard
(215) 831-4616

Northeast Philadelphia

See map of Crisis Response Centers on next page.

CRISIS RESPONSE CENTERS





Transportation in Special Situations

Do you need special help getting to a Mental Health or Substance Abuse Service?



- ▶ Sometimes it's difficult to get transportation to an appointment, or to other Mental Health and Substance Abuse services.
- ▶ Depending on your situation, you may be able to get help with transportation if you cannot afford bus fare, live far away from public transportation or cannot travel without aid.
- ▶ If you need special help getting transportation to a Mental Health or Substance Abuse appointment or program, please tell your counselor, or call WHEELS for help with transportation at 215-563-2000.



What services can I get as part of the Behavioral Health System?

There is no charge for any service, program or treatment which is approved for you.

CBH can arrange for you to:

- get counseling (outpatient clinic) for Mental Health and Substance Abuse problems.
- attend day treatment programs.
- be hospitalized for mental illness or substance abuse.
- get care in an emergency or crisis situation.
A crisis evaluation does not have to be pre-approved.
- get medication you may need for your mental health or substance abuse problem, including methadone.
- go to drug and alcohol detoxification and rehabilitation programs or live in a half-way or a recovery house.
- get in touch with other services you may need through the Office of Mental Health.

If you are deaf, blind, or have a physical disability, CBH will be sure that the provider you use has interpreters and handicapped accessible facilities.



To find out if a provider is covered (or paid for) in the Behavioral Health System, ask your provider or call CBH at 1-888-545-2600.

There are instances when there may be restrictions on where you receive treatment.



Provider List

The Provider List gives you information about hospitals and agencies that serve CBH Members such as:

- their address,
- their phone number,
- the types of service they provide, and
- the languages they speak

Below are three ways that you can get information about the Member Handbook or Provider List:

- It is not required that you call our Member Services hotline but the fastest way to learn about your rights and protections, find services, or learn how to file a grievance or ask for a fair hearing is to call our call center. Our call center is open 24-hours a day, 7 days a week and our Member Services staff are ready to help. The telephone number is 888-545-2600. *This is the best way to get the information you need.*
- You can also see our Member Handbook or Provider List on our website at www.phila-bhs.org. If you do not have the Internet on your home computer, you may want to use a computer at your city branch library.
- If you would like a printed copy of our Member Handbook or Provider List, please call the member services number 888-545-2600 and make your request to a live person who answers your call. You will need to give us your name and address. We can also send you the Member Handbook and/or Provider List on a CD for you to read on your computer.



What if my child or adolescent needs help?

- ▶ If your child has emotional, behavioral or substance abuse problems (problems with drugs or alcohol), CBH will work with you to arrange the services your child needs.
- ▶ CBH has special child and family workers who will set up evaluations and treatment. If there is someone you want your child to see for help, CBH will, if at all possible give the okay for you to do so.
- ▶ In some cases, you will meet with a team of agency workers to plan together the services your child may need. This is called an Interagency Team Meeting (see p. 12).
- ▶ Your child—when appropriate—and others you may wish to include are also part of the team.
- ▶ CBH can help set up, if necessary, services in a child's own home, school or community. These services are sometimes called "wraparound" (*Rehabilitation Services*).
- ▶ If your child has a diagnosis of mental retardation and needs a behavioral health service, he or she can get behavioral health services, including wraparound services.





The Behavioral Health System provides Mental Health and Substance Abuse services for children and teenagers too.

- ▶ If your child is under 14, you must give your permission (say it is okay) for mental health treatment.
- ▶ If your child is 14 years old or older, he or she must give permission for any mental health treatment. He or she can receive treatment without your permission. *The treatment provider will work hard to include you in all parts of the treatment.*
- ▶ Children and teenagers do not need their family's permission to get **substance abuse treatment**. *The treatment provider will work hard to help children tell their families about the care and to include them in the planning and treatment.*
- ▶ If your child is being served by DHS (Department of Human Services), contact your DHS worker or child's Probation Officer, to set up care. Or you may call CBH directly and CBH will contact DHS or the Probation Officer.
- ▶ If you have a complaint, please follow the steps listed in the "What if I am unhappy with my services?" section of this handbook on pages 22 to 44.
- ▶ If services are denied, CBH must send you a letter to let you know. If you are unhappy with the response, you can file a grievance with CBH and/or ask for a DPW fair hearing (Turn to page 22 to find out how to do this).



A note about Interagency Team Meetings and your rights

An Interagency Team Meeting is when you meet with a team of agency workers to plan together the services your child may need.

- ▶ You have the right to be heard at the Interagency Team Meeting and to be treated with dignity and respect by everyone there.
- ▶ No one can pressure you to agree to a treatment plan for your child that you do not agree with.
- ▶ Services that are prescribed, or ordered, by a doctor (psychiatrist or psychologist) for your child may not be denied at this meeting.
- ▶ If CBH decides to deny all or part of the services decided on by your child's doctor(s), CBH must let you know in writing the reason for the denial. CBH must also tell you how to appeal, or ask for a second review, if you do not agree with the denial.
- ▶ If your child is already getting the services that the doctor orders, those services cannot be cut back until 10 days after CBH mails you the letter telling you why the service was denied.
- ▶ If you tell CBH and/or the Department of Public Welfare (DPW) that you want to appeal the decision within 10 days of getting the letter, (see pp. 22 to 44), your child's services will keep going until you get a final decision on your appeal, or until the prescription ends.





For teenagers only



- ▶ If you have a problem with drugs or alcohol, call us at: 1-888-545-2600.
- ▶ It doesn't matter how old you are to get help for a drug or drinking problem.
- ▶ If you are a member of CBH we will help you get better at no cost to you or your family.
- ▶ If you are not sure if you are a member of CBH, please call 1-888-545-2600.
- ▶ We hope you will tell your family. But, if you feel you can't, we will help you without telling them, unless you give us permission in writing.
- ▶ If your problem is not drugs or alcohol, but you are:
 - sad a lot of the time
 - having trouble controlling your anger
 - getting into trouble
 - feeling like you may not want to live anymore
 - or other problems

Call us at the same number: 1-888-545-2600.

- ▶ For these kinds of problems, you can call CBH yourself, if you are 14 or older.
- ▶ If you are younger than 14, we must have your family's permission to offer you help for your mental health treatment. You will need to have them call us at: 1-888-545-2600.



Family's rights

As a parent or a guardian of a child receiving services through CBH, you have certain rights:

- ▶ You have the right to be treated with dignity and respect as the parent or guardian of a child receiving services.
- ▶ You have the right to take part in setting up your child's treatment plans, and to make sure the plan is being followed.
- ▶ You have the right to bring any advocate (person who can help explain your wishes) to treatment planning meetings about your child.
- ▶ You have the right to be sure that your child's records are kept private.
- ▶ If your child is under 14 years old and getting mental health services, you have the right to look at your child's records.
- ▶ You have the right to refuse to have your child follow the treatment plan if you think it is not a good idea. You also have the right to know the risks to your child of not following the plan.
- ▶ You have the right to complain, if you are unhappy with the services your child is using.
- ▶ You have the right to change your child's counselor.
- ▶ You have the right to know the qualifications and job description of any person who is involved with your child's care.
- ▶ You have the right to "Notice and Appeal." This means that, if a service is denied, you must get a letter that tells you so. AND, you have the right to appeal (ask for another review of) that decision (see pp. 22 to 44).



Your rights

As a member of CBH, you have certain rights:



- ▶ You have the right to be treated with dignity and respect.
- ▶ You have the right to confidentiality.
- ▶ You have the right to look at and get a copy of your records from the treatment provider where you receive treatment.
- ▶ It is possible that your record may not have correct information. You have the right to ask that your record be changed
- ▶ You have the right to take part in all decisions about your treatment.
- ▶ You have the right to have your treatment plan explained to you.
- ▶ You have the right to refuse to follow your treatment plan, knowing the risks you might be taking.
- ▶ You have the right to complain if you are unhappy with the services you are using.
- ▶ You have the right to change your counselor.
- ▶ You have the right to know the qualifications and job description of any person who is helping you.
- ▶ You have the right to “Notice and Appeal” which means that if a service is denied you must receive a letter that tells you the service is denied. AND, you have the right to appeal (ask for another review of) that decision (see pp. 22 to 44).



Your rights - Continued

- You have the right to be given information about the different kinds of care and treatment that is paid for by CBH, and what options you have in getting services. You also have the right to ask for and receive the names, addresses, and telephone numbers of service providers near your home. You may do this by calling 1-888-545-2600, or log onto the CBH website at **www.phila-bhs.org**.
- You have the right to know which service providers can help people who do not speak English. If you are more comfortable speaking in a language other than English, Member Services will try to find a treatment program where your first language is spoken.
- You have the right to go to any outpatient treatment program that is “in-network” with CBH (meaning that they have a contract with CBH), as long as the provider offers the kind of treatment that is right for you. If you would like help to know which providers CBH pays for, call 1-888-545-2600.
- If you want to go to a treatment provider that is not in CBH’s provider network, CBH **may** be able to pay for you to go to that provider, on an “out-of-network” basis. You can find out if CBH will be able to pay for out-of-network services by contacting Member Services at 1-888-545-2600, or by having that treatment provider call and ask for “Care Management”.
- You have the right to get a “second opinion” from a qualified professional, at no cost to you. Please call member services if you want help to find another qualified professional.

- You have the right to go into “in-patient” programs to help you with mental health or drug problems, where you are in the program all day and also spend the night there as well. But all service decisions are based upon “medical necessity”, which means that a staff worker at a treatment provider must help to decide if this is what you really need. This means that before you would go into a program where you stay overnight, a doctor or another professional worker must meet and talk with you first, to help decide the best kind of treatment for you.
- You have the right to be free from **any** form of seclusion or restraint as a means of forcing you to do something or in an attempt to get back at you. If you feel that this has been done to you, please contact Member Services at 1-888-545-2600 to report it.
- You have the right to exercise all of the rights listed in this handbook, and CBH will not treat you differently or badly because you have exercised these rights.



Questions about your rights?

*Call CBH Member Services at
1-888-545-2600*



Advance Directives

Mental Health Advance Directives help you plan for your future mental health care in case you become too sick to make your own decisions. You can do this with a Mental health Declaration or by choosing a Mental Health Power of Attorney or both.

A Mental Health Declaration is a written statement. It tells your provider the following:

- what kind of treatment you wish to have
- where you would like to have your treatment take place
- specific directions you have about your mental health care treatment

A Mental Health Power of Attorney lets you name a person to make mental health care decisions for you if you are too sick to make your own decisions. Your Mental Health Power of Attorney will make decisions about your mental health care, based on your written instructions.

Both the Mental Health Declaration and the Mental Health Power of Attorney must be in writing. Just saying what you want is not enough.

If you would like to set up a Mental Health Declaration or a Mental Health Power of Attorney or both please contact the Mental Health Association in Pennsylvania at 1-866-578-3659 or 717-346-0549, or email them at info@mhapa.org. They will send you the forms and answer any questions. It is important that you share your written Mental Health Advance Directives with your mental health care provider. If you do not share your Mental Health Advance Directives with your provider, he/she will not be able to follow them.

If you or your representative have any complaints about Mental Health Advance Directives or don't like the way your provider is handling your Mental Health Advance Directives, you can make a complaint by following the regular complaint process in the CBH Member Handbook. (Please see the "Complaint" section, pages 23-29.)

A note about your rights...

You have the right to confidentiality...



- ▶ Your right to confidentiality means that information about you is kept private.
- ▶ Things that you share about yourself while getting Mental Health or Substance Abuse treatment cannot be shared without your written "okay."
- ▶ When information needs to be shared, no more information may be shared with others than is necessary.
- ▶ In certain cases, such as situations that involve threats to others or self, information may need to be shared without your written okay. In these cases, only information that is absolutely necessary will be shared with others.
- ▶ When information needs to be shared about a child under 14, the parent or guardian must give permission (sign a release form).



Your responsibilities

As a member of CBH, you have certain responsibilities when you use the Behavioral Health System:

- ▶ Please respect the dignity and privacy of others.
- ▶ Please try your best to keep your appointments or call ahead of time to cancel your appointment.
- ▶ Please give true and complete information.
- ▶ Please work with your service provider to help develop your treatment plan.
- ▶ Please tell your counselor if you decide to stop your treatment.
- ▶ Please call the CBH Member Services number to let them know when you change your address.



Illegal acts such as signing someone else's name or using illegal drugs where you get services may mean that you will lose your services.



What if I leave the Philadelphia area and need to get services?

- ▶ If you are planning to move out of the Philadelphia area, call Member Services at 1-888-545-2600. They will help connect you with a service in your new area so that your treatment can continue.



- ▶ If needed, CBH will ask you to sign a release form which will let them share information about you and the services you need with your new provider of service.
- ▶ If you are outside of the Philadelphia area and need emergency Mental Health or Substance Abuse Services, if possible call Member Services before getting those services. If you cannot do that, call Member Services after you get your emergency care.



If you are moving out of the Philadelphia area, call CBH's Member Services at 1-888-545-2600.

They can help you connect with new services.



What if I am unhappy with my services?

- ▶ If you are unhappy with any of your services, please call CBH at 1-888-545-2600 and speak with your Member Services Representative. Or you can write CBH at:



CBH
7TH Floor
801 Market Street
Philadelphia, PA 19107
ATTN: Provider Network Operations

- ▶ CBH has a special way to handle your concerns. Pages 22 to 44 tell you what to do if you have a concern about your mental health or substance abuse services.

Did you know?

You can get help if you are unhappy with your services and want to make a complaint or grievance. There are people who can help you with this process.



What is a Complaint?

- ▶ A complaint is when you tell us you are unhappy with CBH (Community Behavioral Health) or your provider or you do not agree with a decision made by CBH.

These are some examples of a complaint:

- ▶ You are unhappy with the care you are getting.
- ▶ You are unhappy that you may not get the service you want because it is not a covered service.
- ▶ You are unhappy that you have not received services that you have been approved to get.*

*CBH providers must provide services within one hour for emergencies, within 24 hours for urgent situations, and within seven days for routine appointments and specialty referrals. If a treatment plan is approved, services must be provided according to the prescribed treatment plan.

What should I do if I have a Complaint?

First Level Complaint

To file a complaint, you may:

- call CBH at 1-888-545-2600 and tell us your complaint, or

- write down your complaint and send it to us at:



This is called a **first level** complaint.

When should I file a first level complaint?

You must file a complaint **within 45 days of getting a letter** telling you that:

- CBH has decided you may not get a service you want because it is not a covered service.
- CBH will not pay a provider for a service you received.
- CBH did not decide a first level complaint or grievance you filed earlier within 30 days of when you filed it.

You must file a complaint **within 45 days of the date you should have received a service** if your provider did not give you the service.

You may file **all other complaints at any time.**



What is a Complaint? - Continued

What happens after I file a first level complaint?

CBH will send you a letter to let you know we received your complaint. The letter will tell you about the first level complaint process.

You may ask CBH to see any information we have about your complaint. You may also send information that may help with your complaint to CBH.

If you filed a complaint because of one of the reasons listed below, you may be included in the first level complaint review. You must call CBH within 10 business days of the date on the letter to tell us that you want to be included:

- You are unhappy that you have not received services that you have been approved to get.
- You are unhappy that CBH has decided you may not get a service you want because it is not a covered service.
- You are unhappy that CBH will not pay a provider for a service you received.
- You are unhappy that CBH did not decide a first level complaint or grievance within 30 days.

You may come to our offices or be included by phone. You do not have to attend if you do not want to. If you do not attend, it will not affect our decision.

One or more CBH staff, who has not been involved in the issue you filed your complaint about, will make a decision on your complaint. Your complaint will be decided no more than 30 days after we received it.

A letter will be mailed to you no more than 5 business days after CBH makes its decision. This letter will tell you the reason(s) for the decision. It will also tell you how to file a second level complaint if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are not covered services for you, the services will continue until a decision is made.

What if I do not like CBH's decision?

Second Level Complaint

If you are not happy with CBH's first level complaint decision, you may file a **second level** complaint with CBH.

When should I file a second level complaint?

You must file your second level complaint within 45 days of the date you get the first level complaint decision letter. Use the same address or phone number you used to file your first level complaint.



What is a Complaint? - Continued

What happens after I file a second level complaint?

CBH will send you a letter to let you know we received your complaint. The letter will tell you about the second level complaint process.

You may ask CBH to see any information we have about your complaint. You may also send information that may help with your complaint to CBH.

You may come to a meeting of the second level complaint committee or be included by phone. CBH will contact you to ask if you want to come to the meeting. You don't have to attend if you do not want to. If you do not attend, it will not affect our decision.

The second level complaint review committee will have three or more people on it. At least one CBH member will be on the committee. The members of the committee will not have been involved in the issue you filed your complaint about. The committee will make a decision no more than 30 days from the date CBH received your second level complaint.

A letter will be mailed to you within 5 business days after the committee makes its decision. This letter will tell you the reason for the decision. It will also tell you how to ask for an external complaint review if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a second complaint that is hand-delivered or postmarked within 10 days of the date on the first level complain decision letter, the services will continue until a decision is made.

What if I still don't like the decision?

External Complaint Review

If you are not happy with CBH's second level complaint decision, you may ask for a review of your complaint by the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve CBH policies and procedures.

You must ask for an external review within 15 days of the date you receive the second level complaint decision letter.

If you ask, the Department of Health will help you put your complaint in writing. You must send your request for external review in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Attention: Complaint Appeals
P.O. Box 90
Harrisburg, Pennsylvania 17108-0080
Telephone Number: 1-888-466-2787
or
Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone Number: 1-877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department.



What is a Complaint? - Continued

The Department of Health or the Insurance Department will get your file from CBH. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you the reason(s) for the decision and what you may do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped because they are not covered services for you and you file a request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services will continue until a decision is made.



What is a Grievance?

A grievance is what you file when you do not agree with CBH's decision that a service that you or your provider asked for is not medically necessary.

You may file a grievance if CBH does any one of these things:

- denies a service
- approves less than what was asked for
- approves a different service from the one that was asked for

What should I do if I have a Grievance?

First Level Grievance

If CBH does not completely approve a service for you, we will tell you in a letter. The letter will tell you how to file a grievance. **You have 45 days from the date you receive this letter to file a grievance.**

To file a grievance, you may:

- call CBH at 1-888-545-2600 and tell us your grievance, or
- write down your grievance and send it to us at:

CBH
7TH Floor
801 Market Street
Philadelphia, PA 19107
Attn: Quality Review





What is a Grievance? - Continued

or

- your provider can file a grievance for you if you give the provider your consent in writing to do so.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

What happens after I file a first level grievance?

CBH will send you a letter to let you know we received your grievance. The letter will tell you about the first level grievance process.

You may ask CBH to see any information we have about your grievance. You may also send information that may help with your grievance to CBH.

If you want to be included in the first level grievance review, you must call us within 10 days of the date on the letter we sent you to let you know we received your grievance. You may come to our offices or be included by phone. You don't have to attend if you do not want to. If you do not attend, it will not affect our decision.

A committee of one or more CBH staff, including a doctor or licensed psychologist, who have not been involved in the issue you filed your grievance about, will make a decision about your first level grievance. Your grievance will be decided no more than 30 days after we received it.

A letter will be mailed to you no more than 5 business days after CBH makes its decision. This letter will tell you the reason for the decision. It will also tell you how to file a second level grievance if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services you have been receiving are being reduced, changed, or stopped, the services will continue until a decision is made.

What if I do not like CBH's decision?

Second Level Grievance

If you are not happy with CBH's first level grievance decision, you may file a **second level** grievance with CBH.

When should I file a second level grievance?

You must file your second level grievance within 45 days of the date you get the first level grievance decision letter. Use the same address or phone number you used to file your first level grievance.

What happens after I file a second level grievance?

CBH will send you a letter to let you know we received your grievance. The letter will tell you about the second level grievance process.

You may ask CBH to see any information we have about your grievance. You may also send information that may help with your grievance to CBH.



What is a Grievance? - Continued

You may come to a meeting of the second level grievance committee or be included by phone. CBH will contact you to ask if you want to come to the meeting. You don't have to attend if you do not want to. If you do not attend, it will not affect our decision.

The second level grievance review committee will have three or more people on it. At least one CBH member and a doctor or licensed psychologist will be on the committee. The members of the committee will not have been involved in the issue you filed your grievance about. The committee will make a decision no more than 30 days from the date CBH received your second level grievance.

A letter will be mailed to you within 5 business days after the committee makes its decision. This letter will tell you the reason for the decision. It will also tell you how to ask for an external grievance review if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and you file a second level grievance that is hand-delivered or postmarked within 10 days of the date on the first level grievance decision letter, the services will continue until a decision is made.

What if I still don't like the decision?

External Grievance Review

If you are not happy with CBH's second level grievance decision, you may ask for an external grievance review.

You must call or send a letter to CBH asking for an external grievance review within 15 days of the date you received the second level grievance decision letter. Use the same address and phone number you used to file your first level grievance. We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer's name, address and phone number. You will also be given information about the external review process.

CBH will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance, to the reviewer, within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reason(s) for the decision and what you may do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services will continue until a decision is made.

If you need help or have questions about complaints and grievances, you may call CBH's toll-free telephone number at 1-888-545-2600, your local legal aid office, or call the Pennsylvania Health Law Project at 1-800-274-3258.



Expedited Complaints and Grievances

What can I do if my health is at immediate risk?

If your doctor believes that the usual timeframes for deciding your complaint or grievance will harm your health, you or your doctor can call CBH at 1-215-413-3100 and ask that your complaint or grievance be decided faster.

You will need to have a letter from your doctor faxed to 1-215-413-3240 explaining how the usual timeframe of 30 days for deciding your complaint or grievance will harm your health.

If your doctor **does not** fax CBH this letter, your complaint or grievance will be decided within the usual timeframes.

Expedited Complaint

The expedited complaint will be decided by a doctor who has not been involved in the issue you filed your complaint about.

CBH will call you within 3 business days of when we receive your request for an expedited (faster) complaint review with our decision. You will also receive a letter telling you the reason(s) for the decision and how to file a second level complaint, if you don't like the decision. For information on how to file a second level complaint see page 26.

An expedited complaint decision may not be requested after a first level complaint decision has been made on the same issue.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a doctor and at least one CBH member, will review your grievance. The doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

CBH will call you within 3 business days of when we receive your request for an expedited (faster) grievance review with our decision. You will also receive a letter telling you the reason for the decision. It will also tell you how to ask for an expedited external grievance review, if you don't like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call CBH at 1-888-545-2600 within 2 business days from the date you get the expedited grievance decision letter. CBH will send your request to the Department of Health within 24 hours after receiving it.

An expedited grievance decision may not be requested after a second level grievance decision has been made on the same issue.

What kind of help may I have with the complaint and grievance processes?

If you need help filing your complaint or grievance, a staff member of CBH will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you may contact your local legal aid office.

At any time during the complaint or grievance process, you may have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell CBH, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask CBH to see any information we have about your complaint or grievance.

Persons whose primary language is not English

If you ask for language interpreter services, CBH will provide the services at no cost to you.

Persons with Disabilities

CBH will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- providing sign language interpreters;
- providing information submitted by CBH at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review; and
- providing someone to help copy and present information.

NOTE: For some issues you may request a fair hearing from the Department of Public Welfare in addition to, or instead of, filing a complaint or grievance with CBH.

See next page for the reasons you may request a fair hearing.



Department of Public Welfare Fair Hearings

In some cases you may ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something CBH did or did not do. These hearings are called “fair hearings”. You may ask for a fair hearing at the same time you file a complaint or grievance or you may ask for a fair hearing after CBH decides your first or second level complaint or grievance.

What kind of things may I request a fair hearing about, and when do I have to ask for a fair hearing?

If you are unhappy because...

- 1) CBH decided to deny a service because it is not a covered service;
- 2) CBH decided not to pay a provider for a service you received AND the provider can bill you for the service;

You must ask for a fair hearing...

within 30 days of getting a letter from CBH telling you of this decision **or** within 30 days of getting a letter from CBH telling you its decision after you filed a complaint about this issue.

within 30 days of getting a letter from CBH telling you of this decision **or** within 30 days of getting a letter from CBH telling you its decision after you filed a complaint about this issue.

If you are unhappy because...

3) CBH did not decide your first level complaint or grievance within 30 days of when you filed it;

4) CBH decided to deny, decrease or approve a service different than the service your provider requested because it was not medically necessary;

5) CBH provider did not give you a service by the time you should have received it. (The time by which you should have received a service is listed on page 23.)

You must ask for a fair hearing...

within 30 days of getting a letter from CBH telling you that we did not decide your complaint or grievance within the time we were supposed to.

within 30 days of getting a letter from CBH telling you of this decision **or** within 30 days of getting a letter from CBH telling you its decision after you filed a grievance about this issue.

within 30 days from the date you should have received the service **or** within 30 days of getting a letter from CBH telling you its decision after you filed a complaint about this issue.

How do I ask for a fair hearing?

You must ask for a fair hearing in writing and send it to:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32, 2nd Floor
PO Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include the following information:

- the member's name;
- the member's social security number and date of birth;
- a telephone number where you may be reached during the day;
- if you want to have the fair hearing in person or by telephone; and
- any letter you may have received about the issue you are requesting your fair hearing for.

What happens after I ask for a fair hearing?

You will get a letter from the Department of Public Welfare's Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

CBH will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, CBH must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?

If you ask for a fair hearing after a first level complaint or grievance decision, the fair hearing will be decided no more than 60 days from when the Department of Public Welfare gets your request.

If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Public Welfare gets your request.

A letter will be sent to you after the decision is made. This letter will tell you the reasons for the decision. It will tell you what to do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services that are being reduced, changed or stopped, and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter telling you that CBH has reduced, changed, or stopped your services, or telling you CBH's decision about your first or second level complaint or grievance, your services will continue until a decision is made.

What can I do if my health is at immediate risk?

Expedited Fair Hearing

If your doctor believes that using the usual timeframes to decide your fair hearing will harm your health, you or your doctor or licensed psychologist can call the Department of Public Welfare at **1-877-356-5355** and ask that your fair hearing be decided faster. This is called an expedited fair hearing.

You will need to have a letter from your doctor or licensed psychologist faxed to **717-772-7827** explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor does not send a written statement, your doctor may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor **does not** send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled and decided within 90 days.

If your doctor sends a written statement or testifies at the expedited fair hearing, the decision will be made within 3 business days after you asked for the expedited fair hearing.

If there are any major changes to this process, you will get a letter telling you about them. You will get 30 days notice.

If you need help or have questions about fair hearings, you may call CBH's toll-free telephone number at 1-888-545-2600, your local legal aid office, or the Pennsylvania Health Law Project at 1-800-274-3258.



Special Situations

What do I do if CBH discontinues (cuts off) a service I am getting now?

- ▶ Your counselor or doctor must tell you each time they ask CBH to approve a certain service for you.
- ▶ If CBH does not give the okay for the service, CBH must write you with the reason they said no and offer you other (alternative) services.
- ▶ If you are unhappy with the decision, you may file a grievance (see page 30).
- ▶ You have a right to stay in a service while your grievance is being reviewed as long as your counselor or doctor agrees that you need that service, BUT...
- ▶ **In order to stay in your service during this time, you must file a grievance within 10 days of when you get CBH's letter that denies or stops your service.**

What if I am in an urgent situation?

- ▶ If your service is denied and you or your doctor feel your health is at risk, there is an expedited, or *quick*, process to have your concerns reviewed.
- ▶ This means that CBH will have to respond to your concerns or grievance in **12 to 24** hours.



Who can I call for help?

Your CBH Member Services Representative— 1-888-545-2600

- ▶ Your Member Services Representative at CBH is there to help when you have a problem.
- ▶ Their job is to work with you and others to find an answer that you are happy with whenever possible.

The Ombudsperson—215-923-9627

- ▶ The Ombudsperson is your advocate. This means that their job is to help you with mental health or substance abuse concerns.
- ▶ The Ombudsperson is there to help when you have a problem with your services, want to make a complaint, a grievance, or if you need to file an appeal.
- ▶ The Ombudsperson can talk with you about your problem, help you write letters and fill out forms about your concern.

Consumer Satisfaction Team, Inc. (CST)—215-923-9627

- ▶ If you have concerns about a mental health or substance abuse service for adults, children or adolescents, you can call CST.
- ▶ CST listens to you and reports your concerns to the people who pay for your services.

Parents Involved Network (PIN)—215-751-1800

- ▶ If you have a concern about your child or adolescent services, PIN has an Ombudsperson/advocate that will help you with your issue.

For Legal Help:

- ▶ Community Legal Services: 215-981-3700
- ▶ Disabilities Law Project: 215-238-8070



Community Behavioral Health,
or CBH, is committed to providing
you with the mental health and
substance abuse services
that are right for you.

*If you feel that you are not
getting the care you need,
please let us know!*

**Contact your
Member Services
Representative at:
1-888-545-2600**



If you still feel that you need help with your
Mental Health and/or Substance Abuse services,
**there are other places you can turn to for help
with your concerns ...**



Are you having problems with your mental health or substance abuse services?

Are you unhappy with your services?



Are you unhappy with Member Services' response to your problem?



Do you need help reporting a complaint, writing a grievance or filing an appeal?

You may need to speak to an advocate who is ready to help you with these kinds of problems.

**PLEASE CALL:
THE OMBUDSPERSON
at 215-923-9627**



*If you have concerns about
your mental health or
substance abuse services:*

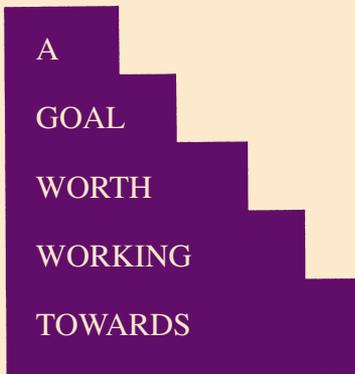
**The Consumer
Satisfaction Team, Inc.
is a place to turn**

“Listening to People First”

**CONTACT US AT:
520 N. Delaware Avenue
7th Floor
Philadelphia, PA 19123
215-923-9627**



**Consumer
Satisfaction**



**A
GOAL
WORTH
WORKING
TOWARDS**



What do these words mean?

Appeal: To ask for another review of your complaint or grievance.

CBH (Community Behavioral Health): Company that pays for you to get mental health and substance abuse services.

Complaint: When you are unhappy with CBH or your provider.

Confidentiality: Information about you is kept private.

Covered service: A service that CBH pays for, like seeing a counselor.

Discontinued service: When you no longer get a service that you used to get.

Grievance: When you are unhappy with CBH because you did not get a service, you got less of a service or you got a different service than your provider (doctor) asked for and that you feel you need.

HMO (Health Maintenance Organization): Company that pays for you to get physical health care.

Ombudsperson: Person who helps you when you have a problem with your mental health or substance abuse services.

Pre-Approval: Getting the okay from CBH that they will pay for a service before you go to that service.

Second Opinion: When you go to a *second* professional to get their suggestions about what treatment is right for you.

The Behavioral Health System's

Community Behavioral Health

**YOUR LINK TO
MENTAL HEALTH &
SUBSTANCE ABUSE
SERVICES**

Name:

Member Services Representative:

**FOR SERVICES CALL:
1-888-545-2600**

Philadelphia's Behavioral Health System
Copyright @ 1999, CST, Inc.
Revised 2004

Philadelphia's Behavioral Health System
Copyright © 1999, CST, Inc.
Revised 2005.2